Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Health and Recovery Services Administration

General Information

To be used with HRSA Billing Instructions

About this publication

Note: This booklet should be used in addition to the billing instructions for each provider's specific scope of care.

This publication incorporates the previous *General Information Booklet*, dated September 2000 and Numbered Memoranda: 01-53 MAA, 03-06 MAA, 04-55 MAA, and 04-57 MAA.

Published by the Health and Recovery Services Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

Copyright Disclosure

HRSA's Billing Instructions and Numbered Memoranda

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at http://maa.dshs.wa.gov (click on the *Billing Instructions/Numbered Memoranda* link).

To request a free paper copy from the Department of Printing:

- **Go to:** http://www.prt.wa.gov/ (Orders filled daily.) Click on General Store. Follow prompts to Store Lobby → Search by Agency → Department of Social and Health Services → Health and Recovery Services Administration → desired issuance; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586-6361/ telephone 360.586-6360. (Orders may take up to 2 weeks to fill.)

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A provider may use HRSA's toll-free lines for questions regarding its program. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. [WAC 388-502-0020 (2)].

Where can I find information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Contact Provider Enrollment:
http://maa.dshs.wa.gov/provrel/
866.545.0544 (toll free)
PO Box 45562
Olympia, WA 98504-5562

Can I be notified when HRSA is revising Washington Administrative Code?

Yes. Visit HRSA's web site:
http://maa.dshs.wa.gov/wacnotices/WACNoticesbyEmail.htm
Or phone HRSA: 800.562.6188 (toll free)

What is HRSA's web site address?

http://maa.dshs.wa.gov

How do I get copies of billing instructions?

To **view and download,** visit HRSA on the web:
http://maa.dshs.wa.gov/ Click on *Billing Instructions/ Numbered Memoranda*

To **have a paper copy sent to you,** visit the Dept. of Printing on the web:
http://www.prt.wa.gov/ Click on *General Store*

Who do I contact if I have questions on…

Payments, denials, general questions regarding claims processing, HRSA managed care plans?

HRSA Customer Service Center for Providers
http://maa.dshs.wa.gov/provrel/
800.562-6188 (toll free)
PO Box 45535
Olympia, WA 98504-5535
Fax: 360.725.2144 or 360.586.1209

Private insurance or third party liability, other than HRSA managed care plans?

Division of Customer Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

Assistance with Electronic Billing?

HRSA/HIPAA E-Help Desk
800.562.6188 ext 4 (toll free) or
e-mail: hipaae-help@dshs.wa.gov
See page A.3 for more information

ACS EDI Gateway, Inc.
800.833.2051 (toll free) or
http://www.acs-gcro.com/

Who do I contact if I have questions on…

Transportation?

Web site:
http://maa.dshs.wa.gov/Transportation/index.html
E-mail:
dcstisstransportation@dshs.wa.gov

Interpreter Services?

Web site:
http://maa.dshs.wa.gov/interpreterservices/
E-mail:
dcstissinterpreter@dshs.wa.gov

Where can I view and download rates?

Visit: http://maa.dshs.wa.gov/ProRates

How do I arrange to have HRSA provide billing training at my work site?

Call Provider Relations at any of the following numbers:

360.725.1022
360.725.1023
360.725.1024
360.725.1027

Or, visit Provider Relations on the web at:
http://maa.dshs.wa.gov/contact/prucontact.asp

How do I obtain DSHS forms?

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web:
http://www1.dshs.wa.gov/msa/forms/eforms.html

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:
Phone: 360.664.6047
Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

How do I find out where my local Community Services Office (CSO) is located?

Visit the on-line CSO:
https://wws2.wa.gov/dshs/onlinecso/findservice.asp

How do I find out where my local Home and Community Services (HCS) office is located?

Visit the HCS web site:
http://www.aasa.dshs.wa.gov/Resources/clickmap.htm

How do I find out where my local Regional Support Network (RSN) is located?

Visit the RSN web site:
http://www1.dshs.wa.gov/mentalhealth/rsnmap.shtml

Electronic Billing and HIPAA

HRSA encourages providers to enroll with ACS EDI Gateway, Inc. to conduct electronic transactions. Providers must complete the ACS EDI Gateway, Inc. enrollment process to become a Trading Partner and conduct electronic transactions with HRSA. Enrollment forms are available for download at: http://www.acs-gcro.com/ Select *Medicaid*, then *Washington State.*

In addition to a billing agent, clearinghouse or software vendor, HRSA provides two forms of electronic claim submission at no cost to the provider: WAMedWeb and/or WINASAP2003. Providers choose which form of claim submission is the best fit for the quantity, complexity, and frequency of their billing practices.

WAMedWeb

- The WAMedWeb is an Internet-based application. No software is downloaded.
- Claims may be processed through a number of different screens. Providers may submit single and batch claims using the WAMedWeb.
- The WAMedWeb also allows providers to **review recent warrant summaries** and allows real time information on **client eligibility** and **claim status**.
- The WAMedWeb may be used by small or large providers.
- The WAMedWeb home page is at: https://wamedweb.acs-inc.com/.

WINASAP2003

- WINASAP2003 is stand-alone software which may be loaded onto a provider's computer from a CD or downloaded from the Internet.
- With WINASAP2003, providers enter their provider information into the software. This initial task can be time consuming but once a provider has loaded the information, the software keeps the data available for quick claim submission.
- WINASAP2003 requires an asynchronous dial-up modem in order to send the information to be processed.
- WINASAP2003 is for providers who submit less than 300 claims.
- WINASAP2003 supports HIPAA compliant 837 transactions.
- The free WINASAP2003 software is available for download at: http://www.acs-gcro.com/ Select *WINASAP2003*, then *Software Download.*

Important Numbers

Acute Physical Medicine & Rehabilitation (PM&R) Authorization **(Providers Only)**	800.634.1398
Ambulance Transportation	800.624.4793
Billing Instructions – Department of Printing Fax requests to 360.568-6361	360.586.6360
Casualty questions	800.894.3754
Coordination of Benefits Section	800.562.6136
Customer Service Center **(Providers Only)**	800.562.6188
Disability Insurance	800.562.6074
Durable Medical Equipment (DME)/Prosthetics & Orthotics Authorization **(Providers Only)**	800.292.8064
Electronic Billing Questions (call this number and press option "4")	800.562.6188
EDI Gateway Enrollment Technical Support	800.833.2051
Fraud Hotline	800.562.6906
HIPAA Help hotline (call this number and press option "4")	800.562.6188
Home Health/Plan of Treatment	360.725.1582
Hospice Notification	800.545.5392
Medical Assistance Customer Service Center (MACSC) **(Clients Only)** Access to Medical Care Broker Transportation Client Complaints or Assistance Healthy Options Enrollment, Disenrollment, Exemptions Interpreter questions	800.562.3022
Medical Eligibility Determination Services (MEDS) Basic Health Plus and State Children's Health Insurance Program (SCHIP)	800.204.6429
Medicare Unit Fax Line	360.664.2186
Pharmacy Authorization **(Providers Only)**	800.848.2842
TAKE CHARGE questions	800.770.4334
Telecommunications Device for the Deaf (TDD)	800.848.5429

HRSA Addresses

Claims for Payment

Electronic Claim Back-up Documentation (ECB)	Division of Program Support PO Box **45560** Olympia, WA 98504-5560
Nursing Home Turnaround Documents (TAD)	Division of Program Support PO Box **9250** Olympia, WA 98507-9250
Paper Copy Claims	Division of Program Support PO Box **9248** Olympia, WA 98507-9248

Claim Inquiries/Provider Correspondence

Provider Correspondence Requests for Issuances/ Publications	Division of Customer Support Medical Assistance Customer Support Center Provider Relations Unit PO Box **45535** Olympia, WA 98504-5535 http://maa.dshs.wa.gov/contact/prucontact.asp

Provider Enrollment Correspondence

Address Changes/Corrections Provider Enrollment	Division of Customer Support Provider Enrollment Unit PO Box **45562** Olympia, WA 98504-5562 http://maa.dshs.wa.gov/ProvRel/change.html
Provider Enrollment for Electronic Claims	ACS EDI Gateway http://www.acs-gcro.com Select *Medicaid*, then *Washington State*.

Third-Party Liability Inquiries

Third-Party Liability
Health Insurance Inquiries

Division of Customer Support
Coordination of Benefits – Health Unit
PO Box **45565**
Olympia, WA 98504-5565

Third-Party Liability
Casualty Insurance Inquiries

Division of Customer Support
Coordination of Benefits – Casualty Unit
PO Box **45561**
Olympia WA 98504-5561

Utilization Review/Authorization Requests

Durable Medical Equipment,
Prosthetics, Orthotics

Division of Medical Management
DME Program Management
PO Box **45506**
Olympia, WA 98504-5506
Fax: 360.586.5299

Dental,
Acute Physical Medicine &
Rehabilitation (Acute PM&R)

Division of Medical Management
Medical Program Management
PO Box **45506**
Olympia, WA 98504-5506
Fax: 360.586.2262

Pharmacy

Division of Medical Management
Pharmacy Prior Authorization
PO Box **45506**
Olympia, WA 98504-5506
Fax: 360.586.2262

Billing Information for HRSA Managed Care Organizations

Note: These names and addresses are subject to change. Visit HRSA's Managed Care web site for information on HRSA managed care organizations: http://maa.dshs.wa.gov/HealthyOptions/index.html

Asuris Northwest Health (ANH)
PO Box 30271
Salt Lake City, UT 84130-0271
Customer Service: 866.240.9560
EDI Help Line: 866.274.4923
http://www.asurisnorthwesthealth.com

Columbia United Providers (CUP, CUPP)
19120 SE 34th St Suite 200
Vancouver, WA 98683
Customer Service: 800.315.7862 or
Local: 360.891-1520
EDI Payer ID = 91162
http://www.cuphealth.com

Community Health Plan of Washington (CHPW, CHPP, CHPG)
Adaptis, Inc
1100 Olive Way, Ste 200
Seattle, WA 98101
Customer Service: 800.440.1561
http://www.chpw.org

Evercare Premier (EVER)
PO Box 659754
San Antonio, TX 78265-9754
Customer Service: 888.867.5511
http://www.unitedhealthcareonline.com

Group Health Cooperative (GHC, GHP)
PO Box 34585
Seattle, WA 98124-1585
Provider Assistance Unit:
888.767.4670
Customer Service: 888.901.4636
http://www.ghc.org

Kaiser Permanente (KHPP)
Claims and Referrals Department
500 NE Multnomah St.
Portland, OR 97232
Customer Service for BH+ 800.813.2000
http://www.kp.org

Molina Healthcare of Washington, Inc. (MHC, MHCP, MINT)
PO Box 22612,
Long Beach, CA 90801
Customer Service: 800.869.7165
EDI Payer ID = 38336
http://www.molinahealthcare.com

Regence Blue Shield (RBS)
PO Box 30271
Salt Lake City, UT 84130-0271
Customer Service: 800.669.8791
EDI Help Line: 866.274.4923
http://www.wa.regence.com

List of HRSA Billing Instructions

Access to Baby & Child Dentistry (ABCD)
Acute Physical Medicine & Rehabilitation (Acute PM&R)
Adult Day Health
Ambulance and Involuntary Treatment Act (ITA) Transportation
Ambulatory Surgery Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Childbirth Education
Chiropractic Services for Children
Dental Program (Adults/Children)
Direct Entry Training Manual
Early, Periodic Screening, Diagnosis, and Treatment (EPSDT)
Electronic Billing Manual
Enteral Nutrition Program
Family Planning Services
Federally-Qualified Health Centers (FQHC)
First Steps Childcare Program
General Information
Healthy Options/Basic Health Plus/SCHIP Instructions for Supplemental Billing
Hearing Aids and Services
HIV/AIDS Case Management
Home Health Services
Home Infusion Therapy/Parenteral Nutrition
Hospice Services
Hospital Inpatient
Hospital Outpatient
Indian Health Services/ Tribal 638/ Tribal Mental Health Services
Kidney Center Services
Long Term Acute Care (LTAC) Program
Maternity Support Services/Infant Case Management
Medical Nutrition Therapy
Neurodevelopmental Centers
Nondurable Medical Supplies and Equipment (MSE)
Nursing Facilities
Occupational Therapy Program
Orthodontic Services
Oxygen and Respiratory Therapy
Physical Therapy
Physician-Related Services (RBRVS)
Planned Home Births and Births in Birthing Centers
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing for Children
Prosthetic and Orthotic Devices
Psychologist
Rural Health Clinic
School Medical Services for Special Education Students
Speech/Audiology Program
TAKE CHARGE Family Planning Supplement
Vision Care Services
Wheelchairs, Durable Medical Equipment & Supplies (DME)

To obtain HRSA's Billing Instructions:

To **view and download**, visit HRSA's web site: http://maa.dshs.wa.gov and click on *Billing Instructions/Numbered Memoranda*.

To **have a paper copy sent** to you, visit the Department of Printing's web site: http://www.prt.wa.gov/ and click on *General Store.*

Definitions

The section defines terms and acronyms used in this booklet.

Alien Emergency Medical – The Alien Emergency Medical (AEM) program is a required, federally-funded program for persons who are ineligible for other Medicaid programs due to citizenship or alien status requirements. It is a very limited program, covering only qualifying emergency medical conditions.
[Refer to WAC 388-438-0110]

Applicant – A person who has applied to DSHS for medical assistance.

Assignment – A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Assignment of Rights – The client gives the state the right to payment and support for medical care from a third party.
[WAC 388-500-0005]

Authorization – HRSA's official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is valid only if the client is eligible on the date of service.

Authorization Number – A nine-digit number, assigned by HRSA, that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Automated Client Eligibility System (ACES) – A data processing system designed to support client, financial, and management activities in DSHS Community Services Offices. Through this system, staff can enter, update and inquire on data relating to assistance units, clients, other agencies, providers, etc.

Basic Health Plus (BH Plus) – A program jointly managed by the Health Care Authority and the Health and Recovery Services Administration for eligible children. Parents can obtain coverage under Basic Health (BH) while their children, if eligible, can be enrolled in the Medicaid BH Plus program. BH Plus offers children the expanded benefits available through HRSA managed care plan benefit packages. This allows BH families to remain together in the same managed care plan. (*Not to be confused with Basic Health, which is sponsored by the Health Care Authority, not HRSA.*)

Benefit Period – The time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for Medicare payments. [WAC 388-500-0005]

Carrier – An organization contracting with the federal government to process claims under Part B of Medicare, or a health insurance plan contracting with the department. [WAC 388-500-0005]

Categorically Needy Program (CNP) – The federally matched Medicaid program that provides the broadest scope of medical coverage.

Children's Health Insurance Program (CHIP) – See **State-Children's Health Insurance Program (SCHIP)**.

Client – An individual who has been determined eligible to receive medical or health care services under any HRSA program.

Code of Federal Regulations (CFR) – Rules adopted by the federal government.

Coinsurance (Medicare) – The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, for which Medicare does not pay. Under Part A, coinsurance is a per-day dollar amount. Under Part B, coinsurance is 20% of reasonable charges. [Refer to WAC 388-500-0005]

Community Services Office (CSO) – An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement – The basic contract that HRSA holds with providers serving HRSA clients.

Current Dental Terminology (CDT™) – A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. The Council on Dental Benefit Programs of the American Dental Association (ADA) publishes CDT.

Current Procedural Terminology (CPT™) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medial Association (AMA).

Deductible (Medicare) – An initial specified amount that is the responsibility of the client.

- **Part A of Medicare-Inpatient Hospital Deductible** – An initial amount of the medical care cost in each benefit period which Medicare does not pay.

- **Part B of Medicare-Physician Deductible** – An initial amount of Medicare Part B covered expenses in each calendar year that Medicare does not pay. [WAC 388-500-0005]

Department – The state Department of Social and Health Services (DSHS). [Refer to WAC 388-500-0005]

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – A program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid. [Refer to WAC 388-500-0005]

Electronic Funds Transfer (EFT) – Automatic bank deposits to a client's or provider's account. [WAC 388-500-0005]

Expedited Prior Authorization (EPA) – The process that a provider uses to create an authorization number using specific codes to indicate to HRSA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

Explanation of Benefits (EOB) – A numeric message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fee-for-service – A payment method HRSA uses to reimburse providers for covered medical services provided to medical assistance clients, except those services provided under HRSA's prepaid managed care programs.

General Assistance-Unemployable (GA-U) – A state-administered program providing cash assistance and medical care services to persons who are unemployable due to incapacity and who are not eligible for or receiving federal aid.

Healthcare Common Procedure Coding System (HCPCS) – This system is a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies.

Healthy Kids Now – A marketing phrase for Washington's children's medical programs.

Healthy Options Program – The HRSA prepaid managed care health program for Medicaid-eligible clients and clients enrolled in the State Children's Health Insurance Program (SCHIP). [WAC 388-538-050]

HIPAA – The Health Insurance Portability and Accountability Act of 1996.

Home and Community Services (HCS) Office – A disabilities and long term care administration office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to adults with functional disabilities.

Integrated Provider Network Database (IPND) – A database developed in partnership by the Health Care Authority and HRSA to provide verified and integrated provider network information of all health plans contracted to serve Basic Health, SCHIP, Healthy Options, GA-U, MMIP, WMIP, and PEBB clients via the Internet and an internal user interface.

International Classification of Diseases (ICD-9-CM) – A standardized system of diagnosis codes issued by the U.S. Department of Health and Human Services.

Julian Date – Consecutively numbered day of the year (e.g., January 1 is 001, January 31 is 031, February 1 is 032, etc.).

Limitation Extension – A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which HRSA routinely reimburses. Limitation extensions require prior authorization.

Managed Care – A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either a managed care organization or a PCCM provider.
[Refer to WAC 388-538-050]

Maximum Allowable Fee – The maximum dollar amount that HRSA reimburses a provider for specific services, supplies, and equipment.

Medicaid – The state and federally funded Title XIX program under which medical care is provided to persons eligible for the Categorically Needy Program or Medically Needy Program.
[Refer to WAC 388-500-0005]

Medicaid Management Information System (MMIS) – A computer system mandated by the federal Centers for Medicare & Medicaid Services for states with Medicaid programs.

Health and Recovery Services Administration (HRSA) The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.
[Refer to WAC 388-500-0005]

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medical Care Services (MCS) – The limited scope of care financed by state funds and provided to General Assistance (GA-U) and ADATSA clients. [WAC 388-500-0005]

Medically Necessary – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medically Needy Program (MNP) – The Medicaid program for aged, blind, or disabled persons, pregnant women, children and refugees with income and/or resources above CNP limits. It provides less medical coverage than CNP.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has several parts including:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

[WAC 388-500-0005]

Medicare Medicaid Integration Project (MMIP) – DSHS's prepaid managed care program that integrates medical and long-term care services for clients who are 65 years of age or older and eligible for Medicare only or eligible for Medicare and Medicaid. Clients eligible for Medicaid only are not eligible for this program.

Patient Identification Code (PIC) – An alphanumeric code that is assigned by DSHS to each HRSA client, consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters or characters (dashes, apostrophes) of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Case Management (PCCM) The health care management activities of a provider who contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services. [WAC 388-538-050]

Primary Care Provider (PCP) – A person licensed or certified under Title 18 RCW including, but not limited to, a physician and advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care. [WAC 388-538-050]

Prior Authorization – A process by which clients or providers must request and receive HRSA approval for certain medical services, equipment, drugs, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization. [Refer to WAC 388-531-0050]

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [Refer to WAC 388-500-0005]

Provider Number – An identification number issued to providers who have a signed contract(s) with HRSA.

Psychiatric Indigent Inpatient – A state funded, limited casualty (LCP) program specifically for mental health clients identified in need of inpatient psychiatric care by the regional support network (RSN). [Refer to WAC 388-865-0217]

Remittance And Status Report (RA) – A report produced by Medicaid Management Information System (MMIS), HRSA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) – Washington State law.

Spenddown – The process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department. [WAC 388-500-0005]

State Children's Health Insurance Program (SCHIP) – The federal Title XXI program under which medical care is provided to uninsured children under age 19 whose family income is between 200% and 250% of the federal poverty level and who are not otherwise eligible under Title XIX of the Social Security Act.

Supplemental Security Income (SSI) – A Federal cash program for aged, blind, or disabled persons. The federal Social Security Administration (SSA) administers the SSI program. [See chapter 388-474 WAC]

TAKE CHARGE – HRSA's 5 year demonstration and research program approved by the federal government under a Medicaid program waiver to provide family planning services.

Temporary Assistance to Needy Families (TANF) – A program offering cash, medical, and other benefits to families in need. [See chapter 388-484 WAC]

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of medical program client. [WAC 388-500-0005]

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Title XXI – The portion of the federal Social Security Act that authorizes grants to states for the Children's Health Insurance Program (SCHIP). [See chapter WAC 388-542 WAC]

Usual and Customary Charge – The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The established charge that is billed the general public for the same services; or
2) If the general public is not served, the established rate normally offered to other contractors for the same services.

See also WAC 388-502-0100(8).

Washington Administrative Code (WAC) – Codified rules of the State of Washington.

Washington Medicaid Integration Partnership (WMIP) – The managed care program that is designed to integrate medical, mental health, chemical dependency treatment, and long-term care services into a single coordinated health plan for eligible aged, blind, or disabled clients [WAC 388-530-050]

WorkFirst – Washington State's response to federal welfare legislation replacing the former Aid to Families with Dependent Children (AFDC) program. The federal government currently sends block grants to states for Temporary Assistance to Needy Families (TANF). [See chapter 388-310 WAC]

Commonly Used Acronyms

Acronym	Description
AAA	Area Agency on Aging
AAG	Assistant Attorney General
ACES	Automated Client Eligibility System
ADA	American Dental Association
ADA	Americans with Disabilities Act
ADATSA	Alcohol and Drug Addiction Treatment and Support Act
ADSA	Aging & Disability Services Administration (DSHS)
AEM	Alien Emergency Medical
AIDS	Acquired Immune Deficiency Syndrome
ALF	Alternative Living Facility
ALJ	Administrative Law Judge
AMA	American Medical Association
AMAC	Automated Maximum Allowable Cost
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgery Center
AWP	Average Wholesale Price
BAU	Base Anesthesia Unit
BH Plus	Basic Health Plus
BI	Billing Instructions
BR	By Report
CAP	Community Alternative Program
CASA	Community AIDS Service Alternative Program
CCF	Congregate Care Facility
CDC	Center for Disease Control
CDT	Current Dental Terminology
CF	Conversion Factor
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health & Medical Program of the Uniformed Services
CHC	Community Health Clinic
CLIA	Clinical Laboratory Improvement Act
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CNP	Categorically Needy Program
COB	Coordination of Benefits (DSHS – HRSA)
COPES	Community Options Program Entry System
CPAS	Claims Processing Assessment System
CPS	Child Protective Services
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist

CSO.....Community Services Office
CUP.....Chemically-Using Pregnant Woman
DAIS .....Division of Audit and Information Systems (DSHS – HRSA)
DASA.....Division of Alcohol and Substance Abuse (DSHS)
DCFS.....Division of Child and Family Services (DSHS – Children's Admin)
DCS.....Division of Child Support (DSHS – ESA)
DCS.....Division of Customer Support (DSHS - HRSA)
DDD.....Division of Developmental Disabilities (DSHS - ADSA)
DDDS.....Division of Disability Determination Services (DSHS - HRSA)
DEERS.....Defense Enrollment Eligibility Reporting System
DEU .....Drug Evaluation Unit
DHHS.....Department of Health and Human Service (Federal)
DMM.....Division of Medical Management (DSHS-HRSA)
DME.....Durable Medical Equipment
DMERC .....Durable Medical Equipment Regional Carrier
DOB .....Date of Birth
DOD.....Date of Death
DOH.....Department of Health (state)
DOS.....Division of Operational Support (DSHS – HRSA)
DPS .....Division of Program Support (DSHS-HRSA)
DRG .....Diagnosis Related Group
DSHS .....Department of Social and Health Services (state)
DUR .....Drug Utilization Review
EAC.....Estimated Acquisition Cost
ECF .....Extended Care Facility
EMC.....Electronic Media Claims
EOB.....Explanation of Benefits
EOMB.....Explanation of Medicare Benefits
EPA.....Expedited Prior Authorization
EPSDT .....Early Periodic Screening, Diagnosis, and Treatment
ESA.....Economic Services Administration (DSHS)
ESLMB .....Expanded Specified Low Income Medicare Beneficiary
ESRD .....End Stage Renal Disease
FECA .....Federal Employee Compensation Act
FFP.....Federal Financial Participation
FFS.....Fee-for-Service
FICA .....Federal Insurance Contribution Act (federal - Social Security)
FPL.....Federal Poverty Level
FQHC.....Federally Qualified Health Center
FSS.....Financial Services Specialist
FSU .....Field Services Unit (DSHS – HRSA – DPS)
FUL .....Federal Upper Limit
GA-H.....General Assistance - Children
GA.....General Administration
GA-U.....General Assistance - Unemployable

GA-W.....General Assistance - ADATSA
GA-X.....General Assistance - Unemployable w/Expedited Categorically Needy
HCA .....Health Care Authority (state)
HCFA.....Health Care Financing Administration (federal – now CMS)
HCPCS.....Healthcare Common Procedure Coding System
HCS.....Home and Community Services (DSHS – ADSA)
HIC.....Health Insurance Code
HIPAA .....Health Insurance Portability and Accountability Act
HIV .....Human Immunodeficiency Virus
HMO .....Health Maintenance Organization
HWD.....Healthcare for Workers with Disabilities
IC.....Issuance Correction
ICD-9-CM.....International Classification of Diseases, 9th Revision, Clinical Modification
ICF .....Intermediate Care Facility
ICN.....Internal Control Number
IDG .....Interdisciplinary Group
IHS .....Indian Health Services
IMD.....Institution for the Mentally Diseased
IMR.....Institute for Mentally Retarded
ISSD.....Information Systems Services Division
ITA.....Involuntary Treatment Act
JCAHO.....Joint Commission on Accreditation of Healthcare Organizations
JRA .....Juvenile Rehabilitation Administration (DSHS)
LCP .....Limited Casualty Program
LCP-MNP .....Limited Casualty Program – Medically Needy Program
LEP .....Limited English Proficiency
LIST .....Language Interpreter Services and Translations (DSHS)
LOS .....Length of Stay
LTC.....Long Term Care
HRSA.....Health and Recovery Services Administration (DSHS)
MAC .....Maximum Allowable Cost
MCO .....Managed Care Organization
MCS .....Medical Care Services
MEDS .....Medical Eligibility Determination Section (DSHS – HRSA – DCS)
MEV.....Medical Eligibility Verification
MHD .....Mental Health Division (DSHS)
MMIP.....Medicare Medicaid Integration Project
MMIS.....Medicaid Management Information System
MNP.....Medically Needy Program
MOA .....Memorandum of Agreement
MSA.....Metropolitan Statistical Area
MSS.....Maternity Support Services
NABP.....National Association Board of Pharmacy
NDC .....National Drug Code
NH.....Nursing Home

OA.....Office of Appeals
OAH.....Office of Administrative Hearings
OBRA .....Omnibus Budget Reconciliation Act
OT .....Occupational Therapy
PA .....Prior Authorization
PCCM .....Primary Care Case Manager/Management
PDDD.....Procedure, Diagnosis, Drug, and DRG File
PEU.....Provider Enrollment Unit (DSHS – HRSA – DCS)
PCP .....Primary Care Provider
PIC .....Patient Identification Code
PII.....Psychiatric Indigent Inpatient
PIP.....Personal Injury Protection (automobile insurance)
PM&R.....Physical Medicine & Rehabilitation (Acute)
POC.....Plan of Care
POS .....Place of Service
POS .....Point of Sale
PRR.....Patient Review and Restriction
PRU.....Provider Relations Unit (DSHS - HRSA - DCS)
PT.....Physical Therapy
QI .....Qualified Individual
QDWI.....Qualified Disabled Working Individual
QMB .....Qualified Medicare Beneficiary
RA.....Regional Administrator
RA.....Remittance Advice
RBRVS .....Resource-Based Relative Value Scale
RCC.....Ratio of Costs-to-Charge
RCW .....Revised Code of Washington
RFP .....Request for Proposal
RHC .....Rural Health Clinic
RSN.....Regional Support Network
RVS.....Relative Value System
RVU .....Relative Value Units
RX.....Pharmaceutical Treatment/Prescription
SCA.....Selective Contracting Area
SCHIP .....State Children's Health Insurance Program
SLMB.....Specified Low Income Medicare Beneficiary
SMIB.....Supplementary Medical Insurance Benefit – Medicare Part B
SNF .....Skilled Nursing Facility
SSPS.....Social Service Payment System
TAD .....Turnaround Document
TANF .....Temporary Assistance to Needy Families
TCS .....Therapeutic Consultation Service
TDD .....Telecommunications Device for the Deaf
TISS .....Transportation & Interpreter Services Section
TOS.....Type of Service

TPL .....Third Party Liability
WAC .....Washington Administrative Code
WMIP.....Washington Medicaid Integration Partnership
WSMA .....Washington State Medical Association

About Medical Assistance

What is Medical Assistance?

Medical assistance is the common phrase used to describe **all** programs available to low-income Washington State residents through the Health and Recovery Services Administration (HRSA).

The following is a list of these programs:

- **Medicaid (federal/state-funded)**
  - ✓ Categorically Needy Program (CNP); and
  - ✓ Medically Needy Program (MNP).
- **Medical Care Programs (state-funded only)**
  - ✓ Alcohol and Drug Addiction Treatment and Support Act (ADATSA)
  - ✓ Family Planning Only Program; and
  - ✓ General Assistance Unemployable (GA-U).
- **Medicare Savings Programs**
  - ✓ Qualified Medicare Beneficiary (QMB);
  - ✓ Specified Low Income Medicare Beneficiary (SLMB);
  - ✓ Expanded Specified Low Income Medicare Beneficiary (ESLMB);
  - ✓ Qualified Disabled Working Individuals (QDWI); and
  - ✓ Qualified Individuals (QI).
- **Mental Health**
  - ✓ Psychiatric Indigent Inpatient (PII).
- **State Children's Health Insurance Program (SCHIP) (federal/state-funded)**
- **TAKE CHARGE Family Planning Program (federal/state-funded) – commonly referred to as TAKE CHARGE**

Procedure Codes and Diagnosis Codes

The following types of codes are used with HRSA's billing instructions:

- American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes;
- American Medical Association (AMA) Current Procedural Terminology (CPT) procedure codes;
- ICD-9-CM diagnosis codes;
- Level II Healthcare Common Procedure Coding System (HCPCS) procedure codes;
- National Drug Code (NDC); and
- UB-92 revenue codes.

HRSA uses the descriptions and guidelines from the most current CPT, HCPCS, CDT, and ICD-9-CM manuals for all HRSA-covered services. HRSA publishes only the short descriptions of CPT codes due to copyright restrictions. Providers must consult their current CPT books for full descriptions.

Note: HRSA adopts Medicare's guidelines and policies whenever possible.

By Report (BR)

HRSA may require a special report for certain services provided to HRSA clients to determine whether the procedure is medically necessary. These services are identified by a **BR** (By Report) in the procedure code listings in certain HRSA fee schedules. This special report **must** include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary for the procedure or service. HRSA may request additional information from the provider.

Border Areas **[Refer to WAC 388-501-175]**

Medical care must be provided to eligible clients in recognized bordering cities following the same policies and procedures as in-state care. The **only** Washington State recognized bordering cities are:

In Idaho:	Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston
In Oregon:	Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria

Provider Requirements

The Health and Recovery Services Administration (HRSA) reimburses enrolled providers for furnishing covered medical services, equipment, and supplies to eligible clients.

Eligibility for Enrollment [Refer to WAC 388-502-0010 (1)]

To be eligible for enrollment, a provider must:

- Be licensed, certified, accredited, or registered according to Washington state laws and regulations; and

- Meet the conditions in this section and in specific program billing instructions regulating the specific type of provider, program, and/or service.

HRSA has reciprocity with other states (except for Involuntary Treatment Act). To be eligible for enrollment, out-of-state providers must meet the eligibility requirements of their state's Medicaid program.

Enrollment [WAC 388-502-0010 (2) and (5)]

- To enroll, an eligible provider must sign a core provider agreement or a contract with DSHS and receive a unique provider number. See the following page for a list of eligible providers who may request enrollment.

- HRSA does not enroll licensed or unlicensed practitioners not specifically addressed in the list on the following page, including, but not limited to:

  - ✓ Acupuncturists;
  - ✓ Counselors;
  - ✓ Sanipractors;
  - ✓ Naturopaths;
  - ✓ Homeopaths;
  - ✓ Herbalists;
  - ✓ Massage therapists;
  - ✓ Social workers; or
  - ✓ Christian Science practitioners or theological healers.

Providers that may Request Enrollment

[Refer to WAC 388-502-0010 (3)]

Professionals	Agencies, Centers, and Facilities	Suppliers of
ARNPs Anesthesiologists Audiologists Chiropractors Dentists Dental hygienists Denturists Dietitians or Nutritionists Maternity case managers Midwives Occupational therapists Ophthalmologists Opticians Optometrists Orthodontists Osteopathic physicians Podiatric physicians Pharmacists Physicians Physical therapists Psychiatrists Psychologists RN Delegators RN First Assistants Respiratory therapists Speech/language pathologists Radiologists Radiology technicians (technical only)	Adult Day Health centers Ambulance services (ground/air) Ambulatory Surgery Centers (Medicare-certified) Birthing Centers (licensed by DOH) Blood banks Chemical Dependency Treatment facilities (certified by DASA and contracted through either a county or DASA) Centers for detox (certified by DASA) CASA agencies Community mental health centers EPSDT clinics Family planning clinics FQHCs (designated by CMS) Genetic counseling agencies Health departments HIV/AIDS case management Home health agencies Hospice agencies Hospitals Indian Health Service Tribal or urban Indian clinics Inpatient psychiatric facilities Intermediate care facilities for mentally retarded (ICF-MR) Kidney centers Laboratories (CLIA certified) Maternity support services agencies Neuromuscular/developmental ctrs Nursing facilities (approved by DSHS ADSA) Pharmacies Private duty nursing agencies Rural health clinics (Medicare-certified) Tribal mental health services (contracted through MHD) Washington state school districts and educational service districts	Durable and nondurable medical equipment and supplies Infusion therapy equipment and supplies Prosthetics/orthotics Hearing aids Oxygen equipment and supplies **Contractors of** Transportation brokers Interpreter services agencies Eyeglass and contact lens providers

General Provider Requirements **[Refer to WAC 388-502-0020]**

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for six years from the date of service** or longer if required specifically by federal or state law or regulation.

- Accept the payment from DSHS as payment in full.

- Follow the billing requirements found in S*ection H - Billing* and WAC 388-538-095 regarding billing managed care clients.

- Fully disclose ownership and control information requested by DSHS.

- Provide all services without discriminating on the grounds of race, creed, color, age, sex, religion, national origin, marital status, or the presence of any sensory, mental, or physical handicap.

- Provide all services according to federal and state laws and rules and billing instructions issued by DSHS.

Providers who will conduct electronic business with HRSA are also required to enroll through ACS EDI Gateway, Inc. (See page A.3 for more information on Electronic Billing.)

> ☞ **Note:** A provider may contact HRSA with questions regarding its programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern DSHS's programs. [Refer to WAC 388-522-0020 (2)]

Denying, Suspending, and Terminating Enrollment

[Refer to WAC 388-502-0030]

- DSHS terminates enrollment or does not enroll or reenroll a provider if, in DSHS's judgement, it may be a danger to the health or safety of clients.

- Except as noted in the next bullet, DSHS does not enroll or reenroll a provider to whom any of the following apply:

  - ✓ Has a restricted professional license;
  - ✓ Has been terminated, excluded, or suspended from Medicare/Medicaid; or
  - ✓ Has been terminated by DSHS for quality of care issues or inappropriate billing practices.

> ☞ **Note:** The Omnibus Budget Reconciliation Act (OBRA) of 1990 permits, under certain circumstances, a physician or dentist to bill for services provided on a temporary basis to their patients by another physician or dentist. In these instances, identify the substituting provider by using a **Q6** modifier next to the procedure code being billed. Document the provider substitution in the client's record.

- DSHS may choose to enroll or reenroll a provider who meets the conditions in the bullet above, if **all** of the following apply:

  - ✓ DSHS determines the provider is not likely to repeat the violation that led to the restriction or sanction;
  - ✓ The provider has not been convicted of other offenses related to the delivery of professional or other medical services in addition to those considered in the previous sanction; and
  - ✓ If the United States Department of Health and Human Services (DHHS) or Medicare suspended the provider from Medicare, DHHS or Medicare notifies DSHS that the provider may be reinstated.

- DSHS gives 30 days written notice before suspending or terminating a provider's enrollment. However, DSHS suspends or terminates enrollment immediately if any one of the following situations apply:

  - ✓ The provider is convicted of a criminal offense related to participation in the Medicare/Medicaid program;
  - ✓ The provider's license, certification, accreditation, or registration is suspended or revoked;
  - ✓ Federal funding is revoked;
  - ✓ By investigation, DSHS documents a violation of law or contract;
  - ✓ The HRSA Medical Director or designee determines the quality of care provided endangers the health and safety of one or more clients; or
  - ✓ DSHS determines the provider has intentionally used inappropriate billing practices.

- DSHS may terminate a provider's number if the provider:

  - ✓ Does not disclose ownership or control information;
  - ✓ Does not submit a claim to DSHS for 24 consecutive months;
  - ✓ Has an incorrect address on file with DSHS;
  - ✓ Requests a new provider number (e.g., change in tax identification number or ownership); or
  - ✓ Voluntarily withdraws from participation in the Medical Assistance program.

Note: Nothing in chapter 388-502 WAC obligates DSHS to enroll all eligible providers who request enrollment.

Voluntary Provider Disenrollment

A provider may voluntarily disenroll by sending a letter to HRSA Provider Enrollment requesting disenrollment. See page A.1 of the *Important Contacts*, for Provider Enrollment contact information.

General Conditions of Payment **[Refer to WAC 388-502-0100]**

- DSHS reimburses for medical services furnished to an eligible client when all of the following apply:

  - ✓ The service is within the scope of care of the client's medical assistance program;
  - ✓ The service is medically necessary;
  - ✓ The service is properly authorized;
  - ✓ The provider bills within the timeframe set in WAC 388-502-0150 (see *Billing* section, page H.1);
  - ✓ The provider bills according to DSHS rules and billing instructions; and
  - ✓ The provider follows third-party payment procedures.

- DSHS is the payer of last resort, unless the other payer is:

  - ✓ An Indian Health Service; or
  - ✓ Crime Victims, through the Department of Labor and Industries; or
  - ✓ A school district for health services provided under the Individuals with Disabilities Education Act.

- The provider must accept Medicare assignment for claims involving clients eligible for both Medicare and Medical Assistance before HRSA makes any payment.

- The provider is responsible for verifying whether a client has Medical Assistance coverage for the dates of service.

- DSHS may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:

  - ✓ DSHS considered the person eligible at the time of service;
  - ✓ The service was not otherwise paid for; and
  - ✓ The provider submits a request for payment to DSHS.

- DSHS does not pay on a fee-for-service basis for a service for a client who is enrolled in an HRSA managed care plan when the service is included in the plan's contract with DSHS.

- Information about medical care for jail inmates is found in RCW 70.48.130.

- DSHS pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by DSHS, whichever is lower.

Client Eligibility

Valid Types of Eligibility Identification

Following are five types of eligibility identification that a client in a medical assistance program can present to identify the medical program for which the client is eligible:

1. A white Medical ID card with green print, issued monthly by the state;

2. A printout of a medical identification screen from the client's local CSO/HCS office;

3. An award letter from the CSO/HCS office;

4. Medical eligibility verification (MEV) receipt provided by an authorized MEV vendor for the date of service. (For more information on MEV, see next page.); **or**

5. A provider-generated printout of the Medicaid Client Eligibility Inquiry Response (270-271 Transaction) from WAMedWeb. (For more information on WAMedWeb see page A.3.)

The Health and Recovery Services Administration (HRSA) strongly recommends that providers make a photocopy of any of the above types of identification for their files each time the client comes to the office. Note that client eligibility periods change; a client may be eligible one month and ineligible the next. HRSA will not pay providers for services rendered to an ineligible client.

Note: Medical assistance program coverage is **not transferable**. If a provider suspects that a client has presented a card belonging to someone else, request to see a photo ID or another form of identification. **Do not accept a Medical ID card that appears to have been altered**.

Medical Eligibility Verification (MEV) Services

- MEV services provide access to on-line HRSA client eligibility data and can be purchased through approved HRSA vendors. (See list of current vendors below.)

- MEV services provide necessary HRSA client eligibility information for billing purposes. When a provider enters the provider number; access code; date of service; and the client's name, birthdate, and/or Social Security Number, the provider will receive eligibility status, availability of other insurance, HRSA managed care plan enrollment status, Medicare enrollment, and other scope-of-care and program restriction information.

- Please contact the vendors listed below directly for further information about their services. HRSA updates the MEV vendor list as new vendors develop MEV services.

☞ **Note:** If the HRSA client presents a valid Medical ID card, but does not appear on an MEV system, **do not deny the client access to services**. Include a copy of the Medical ID card with the claim.

MEV Vendors

The following companies offer MEV services:

Healthcare Data Exchange (HDX)
300 Lindonwood Drive
Malvern, PA 19355
Jonas Dahlen 610.219.9099

MedE America
2525 Midway Drive
Twinsburg, OH 44087
Jackie Brandon 216.425.3241

Medifax (Potomac Group)
2525 Lebanon, Bldg. C, 2nd Fl
Nashville, TN 37214
Monica Cutrell 800.444.4336
Fax: 615.889.5601

National Data Corporation (NDC)
National Data Plaza
Atlanta, GA 30329
Jim Curran 800.994.9100

Envoy
Rob Sikorski 615.231.4746
Fax: 615.231.4842

Provider Advantage (ENVOY)
3685 NW 183rd Avenue
Portland, OR 97229
800.366-5716
Debbie Walker 800.337.5482

☞ **Note:** The WAMedWeb application also gives providers access to client eligibility information. Providers who would like access to the ***free*** WAMedWeb application can enroll now by contacting ACS EDI Gateway via telephone at 800.388.2051 or at https://wamedweb.acs-inc.com/wa/general/home.do

Clients Enrolled in an HRSA Managed Care Plan

Many HRSA clients are enrolled in one of HRSA's managed care plans. These clients should have an HMO identifier in the HMO column on their Medical ID card. Also:

- If the client is enrolled with an HRSA managed care plan, the name and telephone number of the plan will be indicated in the lower right portion of the Medical ID card;
- If the client is enrolled with a PCCM, the Primary Care Provider's name and telephone number will be listed.

A provider-generated printout of the Medicaid Client Eligibility Inquiry Response (270-271 Transaction) from WAMedWeb or a printout from an MEV vendor indicates whether the client is enrolled in an HRSA managed care plan (see page A.3 for more information on WAMedWeb).

HRSA Managed Care Plan:

A client enrolled in an HRSA managed care plan also receives a separate ID card from the plan. **Send all claims for services covered under the client's managed care plan to that plan for payment.** (See page A.8 - *Billing Information for HRSA Managed Care Organizations*.) Depending on the program, HRSA managed care plans cover a range of services. Check the following web sites for the schedule of benefits or covered services in each contract:

- Healthy Options/SCHIP: http://maa.dshs.wa.gov/HealthyOptions/index.html ;
- Basic Health Plus: http://www.basichealth.hca.wa.gov ;
- Medicare/Medicaid Integration Project: http://maa.dshs.wa.gov/mmip ; and
- Washington Medicaid Integration Partnership project: http://maa.dshs.wa.gov/mip .

Note: If a provider serves an HRSA managed care plan client and the provider is not the client's Primary Care Provider (PCP), or the client was not referred by the PCP, contact the PCP to get a referral. Providers may also need to get authorization from the plan for the service provided, especially if the provider is not contracted as a provider with that plan. Call the HRSA managed care plan to discuss payment **before** providing services. (For contact information see page A.7 - *Billing Information for HRSA Managed Care Organizations*.)

☞ **Note:** Newborns of managed care clients are the responsibility of the mother's plan for the first 60 days of the newborn's life. If the mother changes plans, the baby follows the mother.

Primary Care Case Manager/Management (PCCM):

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. **Please refer to the client's Medical ID card for the PCCM**. A provider-generated printout of the Medicaid Client Eligibility Inquiry Response (270-271 Transaction) from WAMedWeb would indicate whether the client was a PCCM client (see page A.3 for more information on WAMedWeb)

☞ **Note:** Women enrolled in a PCCM must have a referral from their PCCM in order for women's health care services to be paid to an outside provider. The reason for this is the Indian clinics that contract as PCCMs do not meet the definition of health carriers in chapter 48.42 RCW. Women enrolled in a PCCM cannot self-refer for women's health care services, they must be referred.

Send PCCM claims for services to **HRSA-Division of Program Support** at one of the addresses listed on page A.5. (See page H.2 – *How do I bill for services provided to PCCM clients?*)

☞ **Note:** If you treat a client who has chosen to obtain care with a PCCM and you are not the PCP, or the client was not referred to you by the PCCM/PCP, **you may not receive payment**. Contact the PCP to get a referral.

Newborns of clients who are connected with a PCCM are fee-for-service until the client chooses a PCCM for the newborn. **Bill all services for the newborn to HRSA.**

Medical Identification (ID) Card

Medical ID Card Information

Each individual or family who meets eligibility requirements for medical assistance is issued a Medical ID card each month. (See exception for TAKE CHARGE clients, below.)

All clients should present a Medical ID card to the provider prior to receiving services. The Medical ID card indicates the client's program and/or insurance coverage and other specific information.

Review the card for the following information:

- Beginning and ending eligibility dates (be sure to check for month/year the services is being performed);
- The Patient Identification Code (PIC);
- Other specific information e.g., Medicare, private insurance, Health and Recovery Services Administration (HRSA) managed care plan coverage, State Children's Health Insurance Program (SCHIP), or Restrictions (Patient Requiring Review); and
- Retroactive or delayed certification eligibility dates, if any.

Note: Medical assistance program coverage is **not transferable**. If you suspect that a client has presented a card belonging to someone else, request to see a photo ID or another form of identification. **Do not accept a Medical ID card that appears to have been altered**.

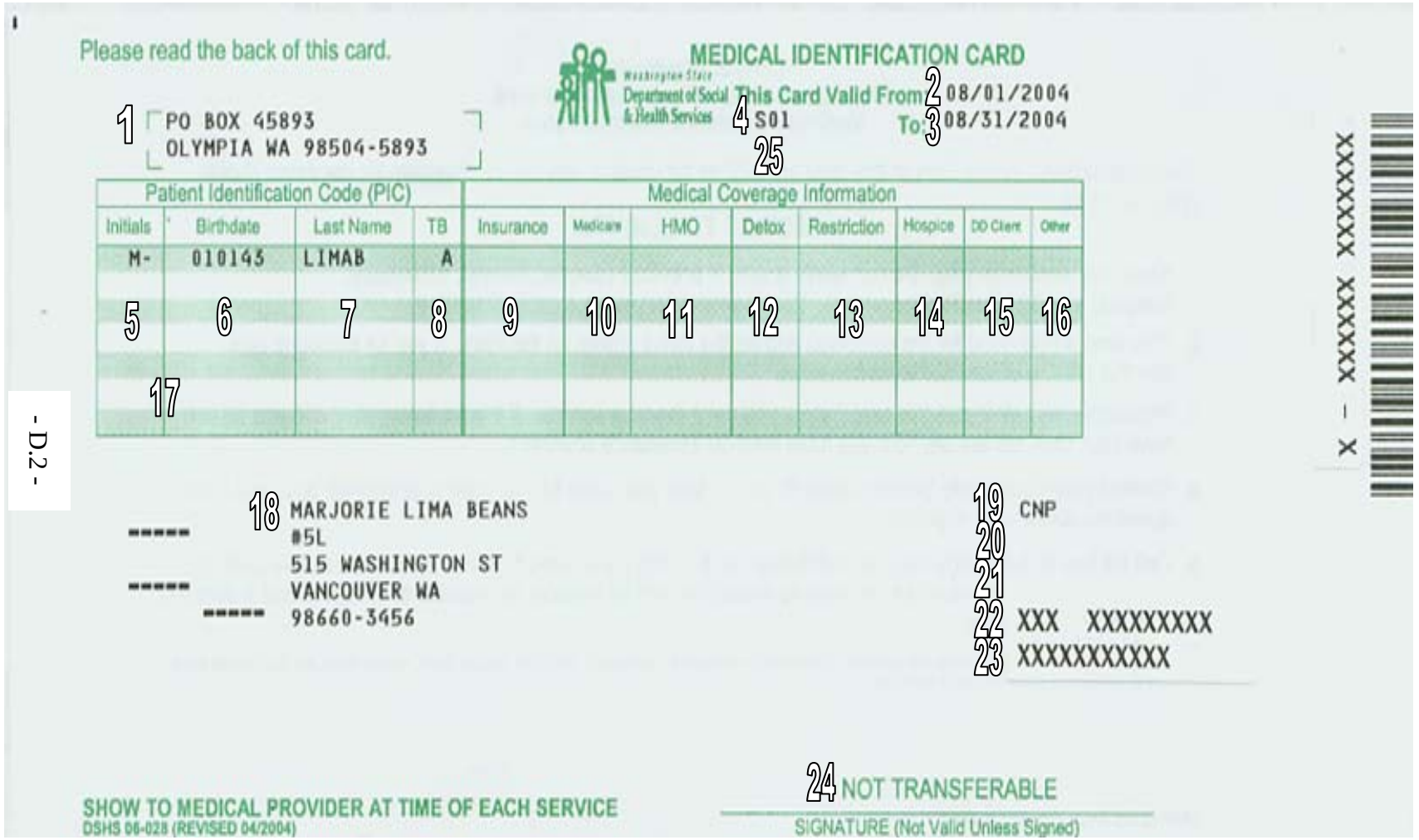
TAKE CHARGE Medical ID Card Information

TAKE CHARGE clients receive a Medical ID card once a year. The card has the words "TAKE CHARGE" in field 19. See page E.4 for more information on TAKE CHARGE.

TAKE CHARGE clients are not eligible for enrollment in an HRSA managed care plan.

The Medical Coverage Group Code is **P06**.

Sample Medical ID Card



Key to the Medical ID Card (MAID)

Field Descriptions		
1.	**Address of CSO/HCS/MEDS**	
2.	**Date eligibility begins**	
3.	**Date eligibility ends**	
4.	**Medical coverage group***	
Patient Identification Code (PIC) Segments		
5.	**First and middle initials** *(or a dash (-) if no middle initial)*	
6.	**Six-digit birth date, consisting of numerals only** (*MMDDYY*)	
7.	**First five letters of the last name** (*and spaces if the name is fewer than five letters*)	
8.	**Tiebreaker** (*an alpha or numeric character*)	
Medical Coverage Information		
9.	**Insurance carrier code**	A four-character alphanumeric code *(insurance carrier code)* in this area indicates the private insurance plan information.*
10.	**Medicare**	*Xs* indicate the client has Medicare coverage.
11.	**HMO** *(Health Maintenance Organization)*	Alpha code indicates enrollment in an HRSA managed care organization. This area may also contain the identifier PCCM *(primary care case manager).* The following ACES medical coverage groups, if not otherwise exempt, are required to enroll in HRSA managed care organizations: F01, F02, F03, F04, F05, F06, H01 and P02.* SCHIP enrollment is limited to F07. GA-U clients in King or Pierce counties, if not exempt are required to be enrolled in an HRSA managed care organization: G01. Clients in the following ACES medical coverage groups can voluntarily enroll in MMIP or WMIP: C01, G02, G03, K01, L01, L02, S01, and S02.
12.	**Detox**	*Xs* indicate eligibility for a 3-day alcohol or a 5-day drug detoxification program.
13.	**Restriction**	*Xs* indicate the client is on restriction or review due to over utilization or inappropriate utilization of medical services. The client is assigned to 1 physician, 1 pharmacist, and/or 1 hospital for nonemergent care. The words "client on review" will also be in field 20.*
14.	**Hospice**	*Xs* indicate the client has elected hospice care.*
15.	**DD client**	*Xs* indicate this person is a client of the DSHS Division of Developmental Disabilities.
16.	**Other**	Letters **A, D, F, J** or **R** indicate that the child is in Foster Care and is eligible for Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings. A – Adoption Support client in Relative Placement D – DDD client in Relative Placement F – Foster Care Placement

J – Juvenile Rehab client in Relative Placement
R – Relative Placement

Medical Coverage Information		
17.	**Health Insurance Claim (HIC)**	Number shown here indicates that the client is on Medicare.
18.	**Name and address**	Name and address of client, head of household or guardian.
19.	**Medical program identifier**	Medical program identifier and medical program name.*
20.	**Other messages**	*(e.g., client on review, delayed certification, emergency hospital only).**
21.	**Telephone number**	Telephone number and name of PCCM or HRSA managed care organization.*
22.	**Local field office**	*Local field office (3 digits)* and ACES assistance unit # *(9 digits).*
23.	**Internal control numbers**	Internal control numbers for DSHS use only.
24.	**Client's signature**	May be used to verify identity of client.
25.	**Client's primary language**.	

*See following pages for further details about this field.

Field 4 – Medical Coverage Group

The codes below are the medical coverage groups found in field 4. These codes identify the type of medical assistance benefits the patient is eligible to receive.

By identifying the client's medical coverage group, the provider can determine the need for additional services such as pregnancy-related First Steps services or the provider can determine if the patient is potentially an enrollee of an HRSA managed care organization.

Medical Coverage Group Codes	Medical Coverage Group Definitions
C01, C95, and C99	Hospice and waiver and Community Based Programs such as COPES, Basic, Basic+, CORE, and Community Protection
D01 and D02	Foster Care and Adoption Support
F01, F02, F03, F04	Family Medical
F05, F06, F08	Children's Medical
F07	State Children's Health Insurance Program (SCHIP)
G01 and G02	General Assistance
G03, G95, and G99 facility	Medical Assistance for a resident of Alternate Living

Medical Coverage Group Codes	Medical Coverage Group Definitions
(ALF)	Facility (ALF)
H01	Legal guardian (children)
I01	Institution for the Mentally Diseased (IMD)
K01,K03,K95, and K99	Long-Term Care – Families
L01, L02, L04, L95, and L99	Long-Term Care – Aged, Blind, Disabled
M99	Psychiatrically Indigent Inpatient
P02, P04, and P99	Pregnancy related
P05	Family Planning Only
P06	TAKE CHARGE
R01, R02, and R03	Refugee
S01, S02, S95, and S99	Aged, Blind, or Disabled (SSI)
S03, S04, S05, and S06	Medicare cost savings
S08	Healthcare for Workers with Disabilities (HWD)
W01, W02, and W03	ADATSA
F09 and S07	Alien Emergency Medical

Field 9 – Insurance Carrier Code

Some clients are covered under *private* health insurance plans. Premiums may be paid by the client, an absent parent, a relative, DSHS, or an employer.

Enrollment in a *private* Health Maintenance Organization (HMO) plan is indicated by an identifier beginning with ***HM, HI,*** or ***HO*** on the Medical ID card. Information can be located in *field 9* on an individual client level, and/or in *field 19* for all members of the family.

Third-party carrier code information is available on the DSHS-HRSA web site at http://maa.dshs.wa.gov/LTPR . The information can be used as an on-line reference, downloaded, or printed. If you do not have access to HRSA's web site, call 800.562.6136 and request that a paper copy or disk of third-party carrier codes be mailed to you.

Field 11 – Health Maintenance Organization (HMO)

This field indicates a client's enrollment in one of HRSA's managed care organizations:

- Basic Health Plus (BH Plus);
- Healthy Options;
- General Assistance-Unemployable (GA-U) (King and Pierce Counties only);
- Washington Medicaid Integration Partnership (WMIP) (Snohomish County only);
- Medicare/Medicaid Integration Project (MMIP);
- State Children Health Insurance Program (SCHIP); or
- Primary Care Case Management (PCCM).

Plan Name	Healthy Options/ SCHIP Identifier	BH Plus Identifier	GA-U Managed Care Identifier	MMIP Identifier	WMIP Identifier
Asuris Northwest Health Plan	ANH				
Community Health Plan of Washington	CHPW	CHPP	CHPG		
Columbia United Providers	CUP	CUPP			
Evercare Premier				EVER	
Group Health Cooperative	GHC	GHP			
Kaiser Foundation Health Plan		KHPP			
Molina Healthcare of Washington	MHC	MHCP			MINT
Regence Blue Shield	RBS				

Plan Policy:

- The client must obtain all medical services covered under a managed care contract with HRSA through plan-designated facilities or providers.

  The HRSA managed care plan is responsible for:

  ✓ Payment of covered services; and
  ✓ Payment of covered services referred by the plan to an outside provider (for specific guidance, contact the HRSA managed care plan using the customer service phone number found on page A.7 or listed on the client's DSHS medical ID card).

Plan Policy: (Continued)

- Some medical services not covered under the HRSA managed care plan's contract may be paid by HRSA if the services are covered benefits under the HRSA fee-for-service program and meet HRSA coverage requirements. Prior authorization may be required (see specific program billing instructions).

- Medical services that are covered under the HRSA managed care plan's contract are not paid by HRSA under the fee-for-service program.

Field 13 – Restriction

[Refer to WAC 388-501-0135]

Clients who use medical services excessively or inappropriately may be assigned to the HRSA Patient Review and Restriction (PRR) program. The purpose of this program is to assist clients in using medical services appropriately. If a client is assigned to this program, there will be **X**s in the **Restriction** column and "Client on Review" will be printed in the **Other Messages** area of the Medical ID card.

These clients select or are assigned a primary care provider (PCP), pharmacy, and/or a hospital for nonemergent care to provide them with their medical services. HRSA does not pay for services rendered by any physician or pharmacy other than the designated PCP or pharmacy, except in cases of emergency or referral by the designated PCP.

- Providers can discover a client's designated PCP, pharmacy, or hospital through the Medicaid Client Eligibility Inquiry Response 270-271 Transaction (see page C.1) or through the Medical Eligibility Verification (MEV) system (see page C.2).

Services provided by the following providers are **not** subject to restriction by the PRR program:

Dentists
Drug Treatment Facilities
Emergency Medical Services
Family Planning Agencies
Home Health Agencies
Medical Transportation Services
Mental Health Facilities
Optometrists
Other Medical Providers
(e.g., Durable Medical Equipment)

If you have questions about the PRR program or wish to report a client for utilization review call 360.725.1780.

Field 14 - Hospice

Hospice Services are available to clients in the Categorically Needy Program (CNP), Medically Needy Program (MNP), and SCHIP.

Terminally ill clients with a life expectancy of 6 months or less may choose to enroll in the Hospice benefit program. When enrolled in the Hospice program, clients ***waive*** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness are coordinated and provided by the designated hospice agency and attending physician ***only***. Other providers **will not be reimbursed** by HRSA for services related to the terminal illness. For further information, refer to HRSA's *Hospice Services Billing Instructions*.

Only services **not** related to the terminal illness/hospice diagnosis may be provided to clients on a fee-for-service basis if covered under the client's HRSA program. For information about an HRSA managed care plan client enrolled in a Hospice program, the provider should contact the client's plan for further information.

Field 19 - Medical Program Identifier and Medical Program Name

Medical Program Identifier (How the program appears on the ID card)	**Full Medical Program Name**
CNP	Categorically Needy Program
CNP **CHIP**	State Children's Health Insurance Program
CNP	Children's Health Program
CNP **Emergency Medical Only**	CNP – Alien Emergency Medical
CNP - QMB	CN-Qualified Medicare Beneficiary
Detox Only	Detox
Family Planning Only	Family Planning Program
GA-U **No Out of State Care**	General Assistance - Unemployable
General Assistance	ADATSA, ADATSA Medical Only
LCP-MNP	Limited Casualty Program -

Medical Program Identifier (How the program appears on the ID card)	**Full Medical Program Name**
	Medically Needy Program
LCP-MNP **Emergency Medical Only**	Medically Needy Program – Alien Emergency Medical
MIP - Emergency Hospital Only **No Out-of-State Care**	Psychiatric Indigent Inpatient (PII) program
QMB – Medicare Only	Qualified Medicare Beneficiary - Medicare Only
TAKE CHARGE Family Planning	TAKE CHARGE

Note: See Section E *Program Descriptions* for further information on each program.

Field 20 – Other Messages

Delayed Certification: Sometimes a person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. In these cases, the eligibility determination date is after the actual month of service and a delayed certification indicator will be listed on the client's Medical ID card. The provider **must** refund any payment(s) received from the client for the period the client is determined to be eligible for medical assistance, and then bill HRSA for those services.

Retroactive Certification: Sometimes an applicant receives a service and then applies to HRSA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **may** refund payment made by the client and then bill HRSA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers may bill HRSA.

Field 21 –Phone # and name of PCCM or HRSA Managed Care Plan

When a client is enrolled with a primary care case manager (PCCM) or an HRSA managed care plan, a PCCM or HMO identifier will appear in the *HMO* column.

The PCCM or HRSA managed care plan name and telephone number will also appear in this area, which is located at the bottom right hand corner of the client's Medical ID card. The HRSA managed care plan/PCCM will be identified only for the first client listed on the Medical ID card. Other family members on the Medical ID card may have a different PCCM. It is the provider's responsibility to obtain information about the other family members' PCCMs or

managed care organizations from the client.

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Medical Program Descriptions

Categorically Needy Program (CNP)

CNP is a Medicaid program in which eligible individuals have full-scope medical/dental coverage (except Orthodontics). Eligible individuals include:

- **Aged -** Individuals 65 years old or older.
- **Blind -** Individuals who meet the social security requirement for blindness.
- **Children under age 19**.
- **Disabled -** Individuals who meet the social security requirement for disability.
- **Families with dependent children.**
- **Newborns -** Automatically eligible for CNP for 12 months if their mother received medical benefits at the time of the child's birth.
- **Pregnant women -** Eligible at any time during pregnancy.

CNP - Emergency Medical Only **[Refer to WAC 388-438-0110]**

This is a Medicaid program for persons who do not meet citizenship requirements but meet all other eligibility requirements for CNP. The scope of care is limited to services needed as a result of an emergency medical condition.

CNP - Qualified Medicare Beneficiaries (CNP-QMB)

This is a Medicaid program for certain low-income individuals who are eligible for Medicare.

- If a service is **covered by Medicare and Medical Assistance**, the Health and Recovery Services Administration (HRSA) pays the deductible and coinsurance up to Medicare's or HRSA's allowed amount, whichever is less.

- HRSA also reimburses for services that are **not covered by Medicare but are covered by Medical Assistance** under the CNP program.

- If the service is **covered only by Medicare and not Medical Assistance**, HRSA pays the deductible and coinsurance up to Medicare's allowed amount.

Children's Health Program (CHP)

[Refer to WAC 388-505-0210]
(Not to be confused with the State Children's Health Insurance Program – SCHIP)

The Children's Health Program (CHP) addresses health concerns of children who:

- Are 17 years of age or younger;
- Are not eligible for Medicaid because of their citizenship status; and
- Have a family income at or below 100 percent of the federal poverty level (FPL).

State Children's Health Insurance Program (SCHIP)

[Refer to Chapter 388-542 WAC]

- SCHIP is a federal/state program that covers medical services for children under age 19 in families whose income is too high to be eligible for Medicaid, but is within 200 to 250% of the Federal Poverty Level. Children who have other medical coverage at the time of application are not eligible for SCHIP.

- SCHIP has the same scope of coverage as the Categorically Needy Program (CNP).

  Premiums

  SCHIP client premiums are paid by the family to DSHS. There is a grace period for nonpayment, but clients who do not pay the premiums for three months are disenrolled from SCHIP.

  Clients must send payments for their monthly premium to:

  DSHS Finance Division
  PO Box 9501,
  Olympia, WA 98507-9501.

  ☞ **Note:** American Indian/Alaska Native (AI/AN) clients are exempt from paying client premiums.

Family Planning Only [Refer to Chapter 388-532 WAC]

This is a state-funded program providing an additional 10 months of family planning services to eligible women who have just ended a pregnancy or completed a delivery. This benefit follows the 60-day, post-pregnancy coverage for women who receive medical assistance benefits during the pregnancy. The program's coverage is strictly limited to family planning services. Visit HRSA's Family Planning web site at: http://maa.dshs.wa.gov/familyplan .

General Assistance - Unemployable (GA-U) and Detox

GA-U and Detox are state-funded programs that provide some medical and emergent dental services for general assistance-unemployable clients. These programs allow a limited scope of medical care within Washington State and border areas; **out-of-state care is not covered**.

Refer to HRSA's specific program billing instructions for limitations (see *Important Contacts* section). Border areas are listed on page A.20 of this General Information Booklet.

Limited Casualty Program – Medically Needy Program (LCP-MNP)

This is a Medicaid program that provides a limited scope of medical care for individuals who do not meet the eligibility income/resource criteria for income assistance. A Medical ID card is issued to the client when medical bills and emergency medical expenses meet the spenddown. Spenddown is calculated based on income and resources.

LCP-MNP - Emergency Medical Only

This is a Medicaid program for persons who are eligible for MNP but do not meet citizenship requirements. The scope of care is limited to services relating to an emergency medical condition.

Medicare Cost Savings Programs

Qualified Medicare Beneficiaries (QMB - Medicare Only)

This is a Medicaid program for certain low-income individuals who are also eligible for Medicare. HRSA pays Part A and Part B Medicare premiums for QMB-eligible clients. The reimbursement criteria for this program are as follows:

- If the service is **covered by Medicare and Medical Assistance**, HRSA pays only the deductible and coinsurance, up to the Medicare or HRSA allowed amount, whichever is less.

- If the service is **covered only by Medicare and not Medical Assistance**, HRSA pays only the deductible and coinsurance up to Medicare's allowed amount.

- If the services are **not covered or are denied by Medicare**, HRSA does not make any reimbursement.

Specified Low-Income Medicare Beneficiary (SLMB)

This is an HRSA program for certain low income individuals who are also eligible for Medicare and meet the income levels (100-119% FPL). Under this program, HRSA pays Medicare Part B premiums. Clients can be dual-eligible (e.g., SLMB and LCP-MNP).

Expanded Specified Low-Income Medicare Beneficiary or Qualified Individual (QI-1)

This is an HRSA program for certain low-income individuals who are also eligible for Medicare. Under this program HRSA pays Medicare Part B premiums. Clients must meet income levels (120-135% FPL) and they **cannot be dual-eligible**.

Medicare Managed Care (Medicare Part C)

States have the option to pay managed care premiums for clients who are eligible for QMB and enroll in a Medicare-approved managed care plan. While states are not required to pay managed care premiums, they **are required** to pay managed care copayments for QMB clients up to Medicare's or Medicaid's allowable copayment (whichever is less).

TAKE CHARGE [Refer to Chapter 388-532 WAC]

TAKE CHARGE is a federal/state funded five-year family planning waiver program. The purpose of the TAKE CHARGE program is to make family planning services available to men and women with incomes at or below 200% of the federal poverty level.

Eligible persons receive pre-pregnancy family planning services to help them plan if or when to have children, and the timing and spacing of pregnancies.

Any medical service provided under the TAKE CHARGE program must be:

- Performed in relation to a primary focus and diagnosis of family planning; and

- Be medically necessary for the client to safely, effectively, and successfully use, or continue to use, the client's chosen contraceptive method.

A provider must be approved by HRSA as a TAKE CHARGE provider to receive reimbursement for services provided to a TAKE CHARGE client unless the provider is a pharmacist, laboratory, or ancillary service provider *and the services are directly related to family planning*.

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Authorization

Prior Authorization

Prior authorization (PA) is the Health and Recovery Services Administration's (HRSA's) approval for certain medical services, equipment, prescription drugs, or supplies that must be obtained before the services are provided to clients. Prior authorization is based on medical necessity and is a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions (LE) are forms of prior authorization.**

HRSA requires providers to obtain prior authorization for many services, items, and supplies (as identified in HRSA's specific program billing instructions) ***before*** providing them to the client.

Refer to HRSA's specific program billing instructions for telephone numbers, fax numbers, and mailing addresses for obtaining authorization for services or items (See *Important Contacts* section*)*. **If you are the provider of a service, it is your responsibility to obtain authorization prior to providing the service(s) when such authorization is required.**

Note: Authorization for services does not guarantee payment. Providers must meet administrative requirements (client eligibility, claim timeliness, third-party insurance, etc.) before HRSA reimburses for services.

Expedited Prior Authorization (EPA)

HRSA uses the EPA process for certain procedures, diagnoses, and prescription drugs. The EPA process is designed to eliminate the need for prior authorization by telephone or fax. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an EPA number, when appropriate. Refer to the specific HRSA billing instructions for the EPA criteria for specific supplies or services (see *Important Contacts* section*)*.

Limitation Extension

HRSA approves LE in cases when a provider can verify that it is medically necessary to provide more units of service (quantity, frequency, or duration) than are allowed in HRSA's billing instructions and Washington Administrative Code (WAC).

> ☞ **Note:** Requests for LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups receive all services.

Some LE authorizations may be obtained using the EPA process. If the EPA process is not applicable, LE may be obtained using the written/fax process. Refer to the individual billing instructions for program-specific LE information.

Exception to Rule **[Refer to WAC 388-501-0160]**

A client and/or the client's provider may request prior authorization for HRSA to pay for a noncovered medical or dental service, or related equipment. This is called an "exception to rule".

- HRSA cannot approve an exception to rule if the exception violates state or federal law or federal regulation.
- For HRSA to consider the request, sufficient client-specific information and documentation must be submitted to the HRSA Medical Director or designee to determine if:
  - ✓ The client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s); and
  - ✓ The requested service or equipment will result in lower overall costs of care for the client.
- The HRSA Medical Director or designee evaluates and considers requests on a case-by-case basis according to the information and documentation submitted from the provider.
- Within 15 working days of HRSA's receipt of the request, HRSA notifies the provider and the client, in writing, of HRSA's decision to grant or deny the exception to rule.

> ☞ **Note:** Clients do not have a right to a fair hearing on exception to rule decisions.

Transportation (Nonemergency) and Interpreter Services

Transportation and Interpreter Services

The Office of Transportation and Interpreter Services (OTIS) within the Health and Recovery Services Administration (HRSA) provides services which assure equal access to DSHS programs and services.

Transportation Services

HRSA provides access to nonemergency transportation services for clients who need help with transportation to get to their medical appointments.

Interpreter Services

HRSA provides access to interpreter services for DSHS clients and applicants, including clients who are deaf, deaf-blind, and hard of hearing, as well as clients with limited English proficiency (LEP).

Note: For emergency transportation information, please refer to the *Ambulance and Involuntary Treatment Act (ITA) Transportation Billing Instructions* (see *Important Contacts* section).

HRSA's Nonemergency Medical Transportation Program

HRSA's nonemergency medical transportation program does the following:

- Assures access to necessary nonemergency medical services for HRSA clients who have no other method of transportation;
- Provides services only to clients who are eligible for an HRSA medical program that covers transportation (e.g., Categorically Needy Program, Medical Needy Program);

- Provides nonemergency transportation through different methods of transportation, including:

  - ✓ Public transit;
  - ✓ Sedans (passenger vehicles);
  - ✓ Vans with and without lifts and ramps;
  - ✓ Certified volunteer drivers; and
  - ✓ Mileage reimbursement and gas vouchers for personal vehicles;

- Provides the least costly transportation appropriate to the client's mobility status and personal capabilities;

- Is coordinated to serve more than one client on a trip, when possible; and

- Reviews requests by clients to install wheelchair lifts or ramps on client-owned vehicles. Program staff (or designees) determine the condition of the vehicle and cost-effectiveness of the request.

Nonemergency Transportation Coverage

HRSA **covers** transportation services when all of the following are true:

- The client is an eligible HRSA client;

- The trip is medically necessary;

- The trip is to a local medical provider for the medical service requested (if no local medical provider is available, transportation can be to the "closest" provider);

- The client is going to a medical appointment covered by the client's HRSA program; and

- The Transportation Broker gives prior authorization and coordinates the service.

HRSA **does not cover** transportation services when any of the following are true:

- The medical service is not covered;

- For enrollees of an HRSA managed care plan, if the transportation services are not authorized by the plan; or

- For enrollees of a Regional Support Network, if the transportation services are not authorized by the Regional Support Network.

Transportation Brokers

HRSA contracts with Transportation Brokers. In accordance with those contracts:

- All nonemergency transportation to and from covered medical services must be arranged by a Transportation Broker;
- Transportation Brokers provide or arrange all transportation originating within specific counties (seepage G.5 and following);
- Clients or their representatives must make transportation requests directly to a Transportation Broker; and
- HRSA does not reimburse nonemergency transportation providers or clients directly; HRSA only reimburses Transportation Brokers.

> ☞ **Note:** HRSA requires a client to contact a Transportation Broker (see the list on the page G.5 and following) at least 48 hours (2 business days) ahead of a medical appointment, and requires a client to notify the Transportation Broker at least 24 hours ahead of an appointment to cancel.

Transportation Brokers may deny transportation requests when:

- The client does not show up for rides, or shows up late;
- The client behaves in a manner that is not safe for self or others;
- The client is disruptive or does something illegal;
- The client does not cooperate with the Transportation Broker's instructions;
- There is at least one medical provider that is closer than the destination the client requested, and the client refuses to try the closer medical provider; or
- The Transportation Broker needs medical information for trip documentation, but the client and/or medical provider refuses to share that information with the Transportation Broker.

> ☞ **Note:** HRSA's nonemergency medical transportation program requires Transportation Brokers and medical providers to share client information to document medical coverage. All information exchanges are protected by the Health Insurance Portability and Accountability Act (HIPAA). Client information remains confidential and is shared only on a "need-to-know" basis.

Scheduling Nonemergency Medical Transportation

Scheduling and coordinating nonemergency medical transportation is the responsibility of the Transportation Brokers, except in the following instances:

- For out-of-state nonemergency commercial air transportation (except border areas – See page A.20), the client or the client's representative must contact HRSA's Transportation Program by

  - ✓ Fax: 360.664-0261;
  - ✓ E-mail: DCSTISSTRANSPORTATION@dshs.wa.gov ; or
  - ✓ Mail: Nonemergency Medical Transportation, PO Box 45534, Olympia WA 98504-5534;

- Client transportation for admission under the Involuntary Treatment Act (ITA) is the responsibility of the Division of Mental Health and is handled by special local ITA providers, where available. See the ITA Transportation section of HRSA's *Ambulance and Involuntary Treatment Act (ITA) Transportation Billing Instructions*;

- Transportation of a client in restraints (also known as "secured") is the responsibility of the local jurisdiction that is transporting the client; or

- Transportation of prone or supine clients or clients who need medical attention en route must be by ambulance as currently required under Washington State law.

See the following pages for a list of
HRSA's Transportation Brokers for each county in the state.

Nonemergency Transportation Broker List

Web: http://maa.dshs.wa.gov/Transportation/
Email: DCSTISSTRANSPORTATION@dshs.wa.gov

Broker	Counties Covered	Telephone Numbers	
		Local	**Long Distance**
Council on Aging Services - Transportation (COAST) P.O. Box 107 South 210 Main Colfax, WA 99111 coast@stjohncable.com Sharon Doramus, *Ombuds/Lead Screener* Gail Griggs, *Broker Manager*	**Asotin, Garfield, Whitman**	**Voice and TDD:** 509. 397.2935	**Voice and TDD:** 800.873.9996
Human Services Council (HSC) 7414 Northeast Hazel Dell Ave Vancouver, WA 98665-8325 bauhsgs@dshs.wa.gov B.J. Jacobson, *Transportation Coordinator* Gail Bauhs, *Broker Manager*	**Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum**	**Voice and TDD:** 360.694.9997	**Voice and TDD:** 800.752.9422
Hopelink 14812 Main St. Bellevue, WA 98007-5245 JHighland@Hope-Link.org Jon Highland, *Customer Service Manager* Jennifer Holliday, *Ombuds* Janis Webb, *Contracts Manager*	**King**	**Voice:** 800.923.7433 **TDD:** 800.246.1646	**Voice:** 800.923.7433 **TDD:** 800.246.1646
Northwest Regional Council (NWRC) 600 Lakeway Drive Bellingham, WA 98225 ShantJE@dshs.wa.gov Judy Shantz, *Broker Manager*	**Island, San Juan, Skagit, and Whatcom** *After hours, TDD users should call the relay service, 800.833-6388, to leave a message	**Voice:** 360.738.4554 **TDD:** 360.676-6749*	**Voice:** 800.8606812 **TDD:** 800.585-6749*
Paratransit Services 4810 Auto Center Way Bremerton, WA 98312 atk@paratransit.net Grant Holliday, *Ombuds* Ann Kennedy, *Broker Manager*		**Voice** all counties 360.377.7007	**TDD** all counties 800.934.5438
	Clallam, Jefferson, Kitsap, and Mason-north		**Voice:** 800.756.5438
	Grays Harbor, Lewis, Mason-south, Pacific, and Thurston		**Voice:** 800.846.5438

Broker	Counties Covered	Telephone Numbers	
		Local	Long Distance
	Pierce		**Voice:** 800.925.5438
	Snohomish		**Voice:** (877) 852.2580
People For People (PFP) P.O. Box 1665 Yakima, WA 98907 tsloan@pfp.org Tracy Sloan, *Transportation Brokering Supervisor* Marcy Durbin, *TISB Manager*	**Benton, Columbia, Franklin, Kittitas, Walla Walla and Yakima**	**Voice:** 509.248-6793 **TDD:** 509.453.1302	**Voice:** 800.233.1624 **TDD:** 800.606-1302 **Fax Ride Requests-**Long Distance Charges: 509.574.5085
Special Mobility Services (SMS) 3102 E. Trent, Suite 210 Spokane, WA 99202 lisam@specialmobility.org Lisa McClure, B*roker Manager* Rusty Koontz, *Regional Manager*	**Adams, Ferry, Grant, Lincoln, Pend Oreille, Spokane and Stevens**	**Voice:** 509.534.9760 **TDD:** 509.534.8566	**Voice:** 800.892.4817 **TDD:** 800.821.7167 **Ride Requests-** Toll Free 888.829.9915
Trancare 225 Ohme Garden Road Wenatchee, WA 98801 greg@applecapital.net Tanya Hill, *Broker Manager* Greg Wright, *Director*	**Chelan, Douglas and Okanogan**	**Voice and TDD:** 509.667.2727	**Voice and TDD:** 800.352.8726

Department of Social And Health Services **Health and Recovery Services Administration** **Division of Customer Support** **Office of Transportation & Interpreter Services** **Campus Mail:** MS 45534 **FAX:** 360.664-0261 **Delivery Addr:** 925 Plum Street, Building 4, 2nd Floor **Mailing Addr:** P.O. Box 45534, Olympia WA 98504-5534 e-mail: DCSTISSTRANSPORTATION@DSHS.WA.GOV	**Transportation Program Managers**: 800.562-3022 (ask for Transport) **Christine Earnest:** Wheelchair Lifts/Conversions **Jeanne Andry Lang:** Out-of-State **Paul Meury** Lead and Information **Allen Richards** HIPAA and Privacy

Spoken Language Interpreter Services

In order to be paid by DSHS, interpreter services must be:

- Coordinated through a DSHS-contracted broker (see page G.9);
- Provided by DSHS-certified or qualified interpreters only; and
- Arranged for by the medical provider.

HRSA requires the medical provider to do all of the following:

- Keep all information confidential;
- Determine if an interpreter is needed; and
- Notify the broker if it is necessary to cancel or change the interpreter appointment.

Interpreter Services Coverage

HRSA **covers** interpreter services when all of the following are met:

- The individual is an eligible HRSA client and has Limited English Proficiency (LEP), or is deaf, deaf-blind, or hard of hearing;
- The medical provider has decided an interpreter is necessary to access medical and health care services covered by the client's HRSA program;
- The interpreter services (spoken languages) are requested in advance from a DSHS-contracted broker or a DSHS/General Administration American Sign Language Contractor; and
- A medical provider with a current HRSA Core Provider Agreement (CPA) requests the interpreter services.

HRSA **does not cover** interpreter services when the services are:

- Requested by someone other than the medical provider;
- Provided for services that are not medically necessary;
- Provided for services that are not covered by the client's HRSA program;
- Provided by a family member;
- Not required by the medical provider because the provider speaks the same language as the client;
- Provided by an interpreter who is not qualified or certified or coordinated through an HRSA-contracted broker; or
- Provided in an inpatient hospital setting.

Note: For more information, visit the HRSA Interpreter Services website: http://maa.dshs.wa.gov/interpreterservices

Interpreter Broker List

http://maa.dshs.wa.gov/interpreterservices/

County Served	Broker	Broker telephone number	
		Local	Long distance
Asotin **Garfield** **Whitman**	**Coast Transportation** Colfax, Washington	**Voice:** 509.397.2935 **FAX:** 509.397.9229	**Voice and TDD:** 800.873.9996
Clark **Cowlitz** **Klickitat,** **Skamania** **Wahkiakum**	**Human Services Council** Vancouver, Washington http://www.irwc.org	**Voice:** 360.694.9997 **FAX:** 360.694.1446	**Voice and TDD:** 800.752.9422
King & **Statewide (after hours)**	**Hopelink** Bellevue, Washington http://hope-link.org/	**Voice:** 800.923-7433 **FAX:** 425.644.9447	**Voice:** 800.923.7433 **TDD:** 800.246.1646
Island **San Juan** **Skagit** **Whatcom**	**N.W. Regional Council Area Agency on Aging** Bellingham, Washington http://www.nwrcwa/.org **After hours, TDD users should call the relay service at 800.833-6388, to leave a message*	**Voice:** 360.738-4554 (Whatcom) **TDD*:** 360.676.6749 (Whatcom) **FAX:** 360.734.5476	**Voice:** 800.860.6812 **TDD*:** **800.**585.6749
Clallam **Grays Harbor** **Jefferson** **Kitsap** **Lewis** **Mason** **Pacific** **Pierce** **Snohomish** **Thurston**	**Paratransit** Bremerton, Washington http://www.paratransit.net/	**FAX:** 360.377.1528 or 360.377.6017	**Voice:** 800.925.5438 (Pierce) **Voice:** 800.756.5438 (Clallam, Jefferson, Kitsap, Mason-North) **Voice:** **800.**846.5438 (Grays Harbor, Lewis, Mason-South, Pacific, Thurston) **Voice:** 877.852.2580 (Snohomish) **TDD:** All Counties

County Served	Broker	Broker telephone number	
		Local	Long distance
			800.934.5438
Benton **Columbia** **Franklin** **Kittitas** **Walla Walla** **Yakima**	**People for People** Yakima, Washington http://www.pfp.org/	**Voice:** 509.248.6793 **TDD:** 509.453.1302 **FAX:** 509.853.2151	**Voice:** 800.233.1624 **TDD:** 800.606.1302
Adams **Ferry** **Grant** **Lincoln** **Pend Oreille** **Spokane** **Stevens**	**Special Mobility Services** Spokane, Washington	**Voice:** 509.534.2016 **TDD:** 509.534.8566 **FAX:** 509.534.6980	**Voice:** 800.892.4817 **TDD:** **800.**821.7167 **FAX:** 888.829-9915
Chelan **Douglas** **Okanogan**	**Trancare** Wenatchee, Washington	**Voice:** 509.667.2727 **FAX:** 509.667.2083	**Voice:** **800.**352.8726

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

The Health and Recovery Services Administration (HRSA) has two timeliness standards, one for initial claims and one for resubmitted claims.

- **Initial Claims**

  ✓ HRSA requires providers to obtain an internal control number (ICN) for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders HRSA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ✓ HRSA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to HRSA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** HRSA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

  ✓ The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

  ✓ The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ➢ The provider fails to meet these listed requirements; and
  - ➢ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill HRSA, the claim will be denied.

☞ **Note:** Newborns of HRSA managed care clients that are connected with a PCCM are fee-for-service until a PCCM has been chosen. All services should be billed to HRSA.

Checking a Client's Medical ID Card for Possible Payers

- **Check the Insurance and Medicare columns** on the Medical ID card:

  Does the client have either private insurance or Medicare? If so, these are the primary payers and must be billed first.

- **Check the HMO columns** on the Medical ID card:

  If the client is enrolled in an HRSA managed care plan, you may need a referral and/or authorization from the plan to provide care for services provided through the managed care contract, except for emergency room visits. If the service is not an emergency and you do not have a referral or authorization, refer the client back to the client's plan or primary care provider (PCP), unless the client is seeking a service for which self-referral is permitted under the contract.

Note: Refer to page C.3 for information on checking a client's Medical ID card for eligibility.

Common Billing Complaints

- One of the most common billing complaints is from clients who receive bills from laboratories or radiologists because the ancillary providers did not receive a copy of the Medical ID card.

Note: It is the medical provider's responsibility to forward a copy of the Medical ID card to all ancillary service providers (e.g., radiology, and laboratory) when the provider orders these services.

- Another common billing complaint is the pharmacist misinterpreting a Point-of-Sale (POS) message as a denial and billing the client instead of calling HRSA for prior authorization.

Note: It is the pharmacist's responsibility to call HRSA for prior authorization (PA) when the pharmacist receives a PA message from the POS system.

Billing an HRSA Client on a Fee-For-Service Program

[Refer to WAC 388-502-0160 (1) through (3)]

- A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if HRSA does not pay for the service because the provider failed to satisfy the conditions of payment in HRSA billing instructions, in chapter 388-502 WAC, and other WAC chapters regulating the specific type of service provided.

- The provider is responsible for verifying whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

- A provider may bill a client only if one of the following situations apply:

  ✓ The client is enrolled in an HRSA managed care plan and the client and provider comply with the requirements in WAC 388-538-095;

  ✓ The client is not enrolled in an HRSA managed care plan, and the client and provider sign an agreement regarding payment for the service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for DSHS review upon request;

  The agreement must include each of the following elements to be valid:

  - A statement listing the specific service to be provided;
  - A statement that the service is not covered by HRSA;
  - A statement that the client chooses to receive and pay for the specific service; and
  - The client is not obligated to pay for the service if it is later found that the service was covered by HRSA at the time it was provided, even if HRSA did not pay the provider for the service because the provider did not satisfy HRSA's billing requirements;

  ☞ **Note:** Providers may use their own agreement form as long as it includes the elements listed above.

  ✓ The client or the client's legal guardian was reimbursed for the service directly by a third party;

- ✓ The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by HRSA; HRSA is not considered insurance;

- ✓ The provider has documentation that the client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under an HRSA medical program. This documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the patient's file for DSHS review upon request. In this case the provider may bill the client without fulfilling the requirements on page H.4 regarding the signed agreement for payment. However, if the patient later becomes eligible for HRSA coverage of a provided service, the provider must comply with the requirements on page H.6;

- ✓ The bill counts toward a spenddown liability, emergency medical expense requirement (EMER), deductible, or copayment required by HRSA; or

- ✓ The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a copayment may be imposed on the client by the hospital, except when:

  - ➢ Reasonable alternative access to care was not available;
  - ➢ The "indigent person" criteria in WAC 246-453-040 (1) applies;
  - ➢ The client was 18 years of age or younger;
  - ➢ The client was pregnant or within 60 days postpregnancy;
  - ➢ The client is an American Indian or Alaska Native;
  - ➢ The client was enrolled in an HRSA managed care plan, including primary care case management (PCCM);
  - ➢ The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or
  - ➢ The client receives waivered services such as community options program entry system (COPES) and community alternatives program (CAP).

Eligibility for a Service after the Service Has Been Provided

[Refer to WAC 388-502-0160(4)]

- If a client becomes eligible for a covered service that has already been provided because the client:

  ✓ Applied to DSHS for medical services later in the same month the service was provided (and is made eligible from the first day of the month) the provider must:

  - Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
  - Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill HRSA for the service.

  -or-

  ✓ Receives a delayed certification[3], the provider must:

  - Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
  - Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill HRSA for the service;

  -or-

  ✓ Receives retroactive certification[4], the provider:

  - Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service; and
  - May refund any payment received form the client or anyone on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

☞ **Note:** Many people apply for a medical program **after** receiving medical services that would be covered under that program. The department may take as long as 45 to 90 days to process medical applications.

If eligible, the client receives a Medical ID card dated the first of the month of application. The Medical ID is **not** noted with either the "retroactive certification" or "delayed certification" identifiers. Providers must treat these clients as the "delayed certification" procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

[3] **Delayed Certification** – Department approval of a person's eligibility for Medicaid made after the established application processing time limits. [WAC 388-500-0005]

[4] **Retroactive Certification** – The 3 calendar months before the month of application. [WAC 388-500-0005]

Other Requirements [WAC 388-502-0160 (5) and (6)]

- Hospitals may not bill, demand, collect, or accept payment from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstance described for hospital emergency rooms on page H.5.

- A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or HRSA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.

  This includes, but is not limited to:

  - ✓ Medical charts;
  - ✓ Radiological or imaging films; and
  - ✓ Laboratory or other diagnostic test results.

How do I bill for clients eligible for both Medicare and Medical Assistance? [Refer to WAC 388-502-0150 (6)]

If a client is eligible for both Medicare and Medical Assistance, and the service is covered by Medicare, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations**. HRSA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill HRSA within six months of the date Medicare processes the claims.

- If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA's initial 365-day requirement for initial claims (see page H.1).

Medicare Part A

Medicare Part A is a health insurance program for:

- ✓ Individuals who are 65 years of age and older;
- ✓ Certain individuals with disabilities (under 65 years of age); or
- ✓ Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white, and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if the client has Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

When billing Medicare for Medicare Part A:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the Medical ID card. Enter the Medical Assistance provider number;
- Accept assignment;
- If Medicare has allowed the service, in most cases Medicare will forward the claim to HRSA. HRSA then processes the claim for any supplemental payments;
- If Medicare does not forward the claim to HRSA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to HRSA for processing. (See *Important Contacts* section, page A.1); and
- When Part A services are totally disallowed by Medicare but are covered by HRSA, bill HRSA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons. See specific program billing instructions for information on using a UB-92 claim form.

Note: Medicare/Medical Assistance billing claims must be received by HRSA within six months of the Medicare EOMB paid date. A Medicare Remittance Notice or EOMB must be attached to each claim.

Medicare Part B

Benefits covered under Medicare Part B include:

- ✓ Physician services;
- ✓ Outpatient hospital services;
- ✓ Home health;
- ✓ Durable medical equipment; and
- ✓ Other medical services and supplies not covered under Part A.

> **Note:** When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on the Medicare remittance notice, it means that the claim has been forwarded to HRSA or a private insurer for deductible and/or coinsurance processing.

If a provider receives a payment or denial from Medicare, but it does not appear on the HRSA Remittance and Status Report (RA), the provider bills HRSA directly with the Medicare EOMB attached. Submit a HCFA 1500:

- If Medicare has made payment, and there is a balance due from HRSA Bill only those lines Medicare paid. Do not submit paid lines with denied lines; this could cause a delay in payment.

- If Medicare denies services, but HRSA covers them, bill only those lines Medicare denied. Do not submit denied lines with paid lines; this could cause a delay in payment.

- If Medicare denies a service that requires prior authorization (PA) by HRSA, HRSA waives the PA requirement but still requires some form of HRSA authorization based on medical necessity.

HRSA's Payment Methodology – Medicare Part B

- HRSA compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. Medicare's payment is deducted from the amount selected.

- For the Qualified Medicare Beneficiary if there is no HRSA allowed amount, HRSA uses Medicare's allowed amount.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.

- If there *is* a balance due, payment is made towards the Medicare deductible and/or coinsurance up to HRSA's maximum allowable.

- HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when:

  ✓ The provider **accepts** assignment; and
  ✓ The total combined reimbursement to the provider from Medicare and HRSA does not exceed Medicare or HRSA's allowed amount, whichever is less.

Medicare Part C

- Benefits covered under Medicare Part C include:

  ✓ Physician services;
  ✓ Outpatient hospital services;
  ✓ Home health;
  ✓ Durable medical equipment; and
  ✓ Other medical services and supplies not covered under Part A.

- If a client is enrolled in a Managed Medicare - Medicare Advantage (Part C) plan submit the claim to the Managed Medicare - Medicare Advantage plan first. Managed Medicare - Medicare Advantage is the primary payer of claims.

- After receiving payment or denial from the Managed Medicare - Medicare Advantage plan, submit the claim to HRSA. Indicate "Managed Medicare" as follows:

  ✓ HCFA/CMS 1500 in field 19;
  ✓ UB-92 in form locator 84; or
  ✓ Electronic billing in the on-line comments.

- HRSA must receive claims within 6 months of the Managed Medicare – Medicare Advantage payment date and must include the Managed Medicare EOB to avoid delayed or denied payment due to late submission.

- HRSA does not accept altered EOB's.

- If the Managed Medicare - Medicare Advantage plan allows a service that requires PA by HRSA, HRSA waives the PA requirement.

Note: Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to your Managed Medicare - Medicare Advantage plan. If Managed Medicare - Medicare Advantage adjusts the payment and the claim has previously been paid, you may submit an adjustment request to HRSA. Submit a new claim if the original claim was denied.

HRSA's Payment Methodology – Managed Medicare - Medicare Advantage (Part C) Plans

In order to receive payment from HRSA, it is necessary to follow the billing guidelines established from the Managed Medicare – Medicare Advantage plan prior to billing HRSA.

If there is a co-payment due on a claim:

- Bill HRSA the co-payment amount for each service or procedure.
- For non capitated co-payment claims ,which require that the Medicare EOB be attached to the claim, you must indicate "Managed Medicare" as follows:
  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.
- For capitated co-payments ,which do not require the biller to submit with an EOB, indicate "Managed Medicare capitated co-payment" and line item number as follows:
  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.
- Bill services using the appropriate level of coding.

Note: HRSA pays co-payments as indicated when there is a co-payment due for services rendered.

If there is coinsurance or deductible due on a claim:

If there is a balance due:

- Bill all services, paid or denied, to HRSA on one claim form, and attach an EOB.
- Indicate "Managed Medicare as follows:
  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.
- HRSA will compare the allowed amount for HRSA and Managed Medicare – Medicare Advantage and select the lesser of the two.
- Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage.

If there is no balance due, the claim will be denied.
If there is coinsurance, deductible, and co-payment due on a claim:

- Bill all on the same claim form. Bill the services to HRSA exactly as they appear on the Medicare advantage EOB

- Indicate "Managed Medicare" and line item number for the co-payment as follows:

  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.

If the Medicare Advantage plan allows a service that normally requires PA by HRSA, HRSA will waive the PA requirement.

QMB (Qualified Medicare Beneficiaries) Program Limitations

For clients who are Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program (Clients who have CNP or MNP identifiers on their Medical ID card in addition to QMB):

- If Medicare and HRSA cover the service, HRSA pays only the deductible, co-pay and/or coinsurance up to Medicare or HRSA's allowed amount, whichever is less.
- If only Medicare covers the service and HRSA does not, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only HRSA covers the service and Medicare does not and the service is covered under the CNP or MNP program, HRSA reimburses for the service.
- If HRSA does not have an allowed amount for Managed Medicare – Medicare advantage (formerly Medicare + choice), HRSA pays up to the full co-payment amount

QMB-Medicare Only

For QMB-Medicare Only clients (Clients who have only QMB identifiers on their Medical ID card):

- If Medicare and HRSA cover the service, HRSA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare covers the service and HRSA does not, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.
- If Medicare does not cover the service, HRSA does not reimburse the service.
- If HRSA does not have an allowed amount for Managed Medicare-Medicare Advantage (formerly Medicare + Choice) HRSA pays up to the full co-payment amount.

How to Complete the HCFA-1500 Claim Form

Note: HRSA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section

The CMS-1500, HCFA-1500, U2, 12-90, or the Health Insurance Claim Form is a universal claim form. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing HRSA. Some field titles may not reflect their usage for a particular claim type.

If you do not follow these instructions, your claims may be denied or suspended for further processing, also known as adjudication. Either one of these actions will extend the time period for payment.

Guidelines/Instructions for Paper Claim Submission:

- In order for the claim to be read by the OCR, red ink on the blank claim form must be either Sinclair Valentine J6983 or OCR Red Paper. Paper claims must be submitted using these scannable red inks. These inks cannot be duplicated by a computer printer.
- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" or similar statements on claim form.
- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.
- **Use upper case** (capital letters) for all alpha characters.
- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Place only six detail lines on each claim form**. HRSA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.
- **Total each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form. Do not indicate "continued" on claim forms.

HCFA 1500 Field Descriptions

Field No.	Name	Field Required	Entry
1a.	**Insured's ID No.**	Yes	Enter the Patient Identification Code (PIC) – an alphanumeric code assigned to each HRSA client – exactly as shown on the Medical ID card which consists of the client's: • First and middle initials (a dash [-] *must* be used if the middle initial is not available). • Six-digit birthdate, consisting of *numerals only* (MMDDYY). • First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. • An alpha or numeric character (tiebreaker). • Apostrophes, hyphens and other special characters in a last name are valid and take the place of a letter. *For example:* ➢ Mary C. Johnson's PIC looks like this: MC010667JOHNSB. ➢ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B ➢ John O'Henry's PIC looks like this: J-102564O'HENA.
2.	**Patient's Name**	Yes	Enter the last name, first name, and middle initial of the client (the receiver of the services for whom you are billing).
3.	**Patient's Birthdate**	Yes	Enter the birthdate of the client.
4.	**Insured's Name (Last Name, First Name, Middle Initial)**		When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, TRI-CARE, or TRI-CAREVA) enter the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word *Same* may be entered.
5.	**Patient's Address**	Yes	Enter the address of the client who received the services you are billing for (the person whose name is

Field No.	Name	Field Required	Entry
			in Field **2**.)
9.	**Other Insured's Name**		If there is other (secondary) insurance (Field 11d), enter the last name, first name and middle initial of the person who holds the other insurance. If the client has other insurance and this field is not completed, payment of the claim may be denied or delayed.
9a.	**Other Insured's Policy or Group Number**		Enter the other insured's policy or group number *and* insured's SSN.
9b.	**Other Insured's Date of Birth and Gender**		Enter the other insured's date of birth and gender.
9c.	**Employer's Name or School Name**		Enter the other insured's employer's name or school name.
9d.	**Insurance Plan Name or Program Name**		Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance). **Please note:** DSHS, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are **inappropriate** entries for this field.
10.	**Patient's Condition Related To**	Yes	Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in Field **24**. ***Indicate the name of the coverage source in field* 10d** (L&I, name of insurance company, etc.).
11.	**Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**		Primary insurance, when applicable. This information applies to the insured person listed in Field **4**. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid is the payer of last resort.
11a.	**Insured's Date of Birth**		Primary insurance. When applicable, enter the insured's birthdate, if different from Field **3**.
11b.	**Employer's Name or School Name**		Primary insurance. When applicable, enter the insured's employer's name or school name.
11c.	**Insurance Plan Name or Program Name**		Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(***Note***: This may or may not be associated with a group plan.)*

Field No.	Name	Field Required	Entry
11d.	**Is there another Health Benefit Plan?**	Yes if secondary insurance.	Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed Fields **9a.-d**. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.
17.	**Name of Referring Physician or Other Source**		When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name.
17a.	**ID Number of Referring Physician**		When applicable, 1) enter the 7-digit HRSA-assigned physician number. Refer to the Provider Number Reference website: http://pnrmaa.dshs.wa.gov; 2) If the referring provider does not have an HRSA-assigned ID number, enter 8900946. Use this standard number **only** for referring providers who do not have an HRSA assigned ID number; or 3) When the PCCM referred the service, enter his/her 7-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this Field when you bill HRSA, the claim will be denied.
19.	**Reserved for Local Use**		This field is used for comments that require an HRSA claims specialist to review a claim before payment is made. Examples of appropriate comments: • "B" for baby on a parent's PIC • "Twin A" or "twin B" • "Triplet A", "triplet B", or "triplet C" • "ITA client" • "NDC" • "backup attached" Inappropriate comments may result in delayed processing of claims.
21.	**Diagnosis or Nature of Illness or Injury**		Enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.
22.	**Medicaid Resubmission**		When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

Field No.	Name	Field Required	Entry
23.	**Prior Authorization Number**		When applicable. If the service or hardware you are billing for requires prior authorization, enter the assigned 9-digit number. (See Field **24K** for Expedited Prior Authorization (EPA) numbers).

Field No.	Name	Field Required	Entry
24.	**Enter only one (1) procedure code per detail line (Fields *24A* - *24K*).** If you need to bill more than 6 lines per claim, please use an additional HCFA-1500 claim form.		
24a.	**Date(s) of Service**	Yes	Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., June 04, 2005 = 060405).
24b.	**Place of Service**	Yes	Enter the appropriate **two digit** code as follows: **Code Number** — **To Be Used For** 11 — Office 31 — Skilled Nursing Facility 32 — Nursing Facility
24d.	**Procedures, Services or Supplies CPT/HCPCS**	Yes	Enter the appropriate procedure code for the service(s) being billed. Modifier: **When appropriate enter a modifier**. If there is more than one modifier, begin the list of modifiers with "99" (e.g., 99 80 59)
24e.	**Diagnosis Code**	Yes	Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in **24D**). A valid diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume or relate each line item to Field 21 by entering a 1, 2, 3, or 4. The first diagnosis should be the principle diagnosis. Follow additional digit requirements per ICD-9-CM.
24f.	**$ Charges**	Yes	Enter your usual and customary charge for the service performed. If billing for more than one unit, enter the total charge of the units being billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.
24g.	**Days or Units**	Yes	Enter the total number of days or units (up to 999) for each line. These figures must be whole units.
24k.	**Reserved for Local Use**		When applicable. Enter the required 9-digit EPA number only on the detail line to which the EPA number specifically applies.
25.	**Federal Tax ID Number**		Leave this field blank.

Field No.	Name	Field Required	Entry
26.	**Patient's Account Number**		Not required (optional field for internal purposes). Enter an alpha or numeric character only. For example, a medical record number or patient account number. Do not enter spaces or the following characters in this field: ***** (asterisk) **~** (tilde) **:** (colon) This number will be printed on your *Remittance and Status Report (RA)* under the heading *Patient Account Number*.
28.	**Total Charge**	Yes	Enter the sum of all charges indicated in Field 24F. Do not use dollar signs or decimals in this field.
29.	**Amount Paid**		If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from a source(s) other than insurance, specify the source in Field **10d**. Do not use dollar signs or decimals in this field or put prior Medicare or Medicaid payments here.
30.	**Balance Due**	Yes	Enter total charges minus any amount(s) in Field **29**. Do not use dollar signs or decimals in this field.
33.	**Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**	Yes	Enter the provider's *Name* and *Address* on all claim forms. **PIN #**: This is the seven-digit number assigned by HRSA to identify the performing individual when the individual is part of a group (e.g., the MD/ARNP, etc. who performed the service). **Grp #**: This is the seven-digit number assigned by HRSA to the billing entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made to this number. **Note**: **When billing a Grp#, you must include a performing provider number in the PIN# field.**

For questions regarding claims information, call HRSA toll-free:

1-800-562-3022

Coordination of Benefits

The Health and Recovery Services Administration (HRSA) is required by federal regulation to determine the liability of third-party resources that are available to HRSA clients. HRSA must assure that all resources available to the client that are applicable to the costs of medical care are used. Once the applicable resources are applied, HRSA may make payment on the balance if the third-party payment is less than the amount allowed by HRSA.

To be eligible for HRSA programs, a client must assign his/her insurance rights to the state in conformance with federal requirements.

It is the provider's responsibility to bill HRSA appropriately only after first pursuing any potentially liable third-party resource when:

- Health insurance is indicated on the client's Medical ID card; or
- There is a possible casualty claim and there are immediate funds available (e.g., Personal Injury Protection - PIP); or
- There is reason to believe insurance is available.

☞ **Note:** For assistance in identifying an insurance carrier, refer to the list of Insurance Carrier Codes at http://maa.dshs.wa.gov/LTPR or call the Coordination of Benefits section at 800.562-6136.

Exception:

The following services will not be denied for third-party coverage **unless the third-party liability (TPL) code is HM, HI, or HO**:

- ✓ Outpatient preventative pediatric care;
- ✓ Outpatient maternity-related services; and
- ✓ Accident related claims, if the third party benefits are not available to pay the claims at the time they are filed, per 42 CFR 433.139 (c).

Indicate all available insurance information on the claim form. HRSA pays the claim and pursues the third-party insurance.

☞ **Note:** For further information, refer to HRSA's specific program billing instructions.

Providers must pursue collection from the subscriber when the client is not the subscriber and the insurance company makes a benefit payment to the subscriber. Under these circumstances, the client is under no obligation to pay for service unless the client is the insurance subscriber.

Although the initial submission billing time limit for HRSA is 365 days, an insurance carrier's time limit on billing allowances may be different. It is the provider's responsibility to meet the insurance carrier's requirement relating to billing time limits prior to any payment by HRSA.

If a provider receives payment from HRSA in excess of the amount due, the provider may:

- Refund the excess to the Office of Financial Recovery.
  Mail refund checks to:
  Office of Financial Recovery – MED
  PO Box 9501
  Olympia WA 98507-9501;

  -or-

- Submit an **Adjustment Request**, DSHS form 13-715 to HRSA to withhold money from future checks.
  The **Adjustment Request** form is available on-line from DSHS at:
  http://www1.dshs.wa.gov/msa/forms/eforms.html
  or request a form via phone: **360.664-6047** or fax: **360.664-6186**.

> ☞ **Note:** Attach a copy of the appropriate HRSA Remittance and Status Report showing the original payment. Attach a copy of the insurance Explanation of Benefits (EOB), if available, to either the check or the adjustment request.

Types of Insurance Claims

Casualty Claims

☞ **Note:** For information about casualty claims call 800.894-3754.

HRSA considers claims with possible trauma-related injury diagnosis codes (ICD-9-CM, 800 - 990) as casualty claims. When a provider submits a claim to HRSA, the provider must attach a completed injury report to help HRSA resolve third-party liability issues. **Casualty claims routinely investigated for possible third-party coverage are:**

- ✓ Motor vehicle accidents;
- ✓ Accidents occurring in a place of business, public building, in the home or on the property of another person;
- ✓ Litigation involving a malpractice claim;
- ✓ Department of Labor and Industries claims;
- ✓ Injury diagnoses and services performed in a hospital; or
- ✓ Injury diagnoses and claims over $30.00.

While a provider's HRSA claim is pending investigation, the provider must call HRSA only if the provider has **additional** insurance information. When the investigation is completed, HRSA makes payment or gives the provider the name and address of the party responsible for payment.

If the provider receives payment from an insurance company for services that have been paid by HRSA, the provider must immediately refund to HRSA either HRSA's payment or the insurance payment, whichever is less. If the refund is not made within 30 days, HRSA recovers the lesser payment.

Mail refund checks to:
Department of Social and Health Services
COB Casualty Unit
PO Box 45561
Olympia, WA 98504-5561

Health Insurance Claims

Third-party liability claims other than those for trauma-related injuries are considered health insurance claims. **These claims are routinely held for Third-Party Resources (TPR) investigation when:**

- HRSA's records indicate insurance benefits are available through a third party; or
- Other resources are indicated on the claim or attachment (name of insurance company, insurance pending, etc.).

CHAMPUS

The Washington State Medicaid program coordinates benefits with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in a special way. When an HRSA client is also CHAMPUS-eligible, the insurance code identifier **HI50** will appear in the Insurance area of the Medical ID card.

Active duty military clients have an insurance designation of HI00 on their Medical ID cards. These clients need to be directed to use their military facility. Emergent or referred services for clients with **HI00** should be billed to the military.

When you are presented with a Medical ID card indicating CHAMPUS coverage, or you are aware of the client's CHAMPUS eligibility, you should determine the following:

1. What is the client's zip code area? (Known by CHAMPUS as the catchment area.) Residents with certain zip codes are required to obtain non-emergent hospital inpatient services from the local military hospital. If residents with these zip codes do not go to a local military hospital for treatment, they must obtain a CHAMPUS DD Form 1251 - Nonavailability Statement. HRSA requires this form prior to making payment on these claims. Form 1251 is *not* required for emergent hospital inpatient services or other medical services not requiring hospitalization.

2. Is the client enrolled in DEERS (the Defense Enrollment Eligibility Reporting System)? DEERS eligibility is required by CHAMPUS before CHAMPUS will make payment. To receive reimbursement from HRSA for services provided to CHAMPUS ineligible clients, you should obtain a written denial from CHAMPUS. The denial will state *"Sponsor not on DEERS or not enrolled in DEERS."* Claims submitted to HRSA with these denials attached will be paid by HRSA according to departmental policies.

☞ **Note:** When dealing with CHAMPUS/DEERS clients, ask to see the client's military ID card to determine current military status; this information may be useful for billing CHAMPUS. Look at both sides of the military ID card for essential information related to service restrictions. **If you have additional questions regarding CHAMPUS requirements, you may call the Coordination of Benefits toll-free line at 800.562-6136.**

Veteran's Affairs

The Washington State Medical Assistance program coordinates benefits with the Department of Veterans Affairs (VA) in a special way. When a client of one of HRSA's medical programs is also VA eligible, the identifier **VE02** appears in the Insurance area

of the Medical ID card.

When you are presented with a Medical ID card indicating **Veterans Administration** or you are aware of the client's VA eligibility, obtain current information on VA benefits and claims procedures by calling the nearest VA regional office. A call to 800.827-1000 from any location in the United States will be automatically routed to the nearest VA regional office. VA medical center admissions offices are the primary source for information regarding medical care eligibility. They can provide information on all types of medical care, including nursing home coverage. Many VA medical centers operate outpatient clinics either in the office or in other locations. Individuals with VA eligibility are required to seek medical care through their VA providers as **their primary insurance**.

HMO-Related Claims (Other than HRSA Managed Care)

Some Medical ID cards will display an **HM, HI, or HO** identifier in the *insurance* area of the Medical ID card. This indicates that the client has insurance through a Health Maintenance Organization (HMO). Clients who have insurance through an HMO must comply with the requirements of their plan.

- All medical services covered by the HMO must be obtained through the designated facility or provider. HRSA does not pay for services referred to an outside provider by an HMO. This is the responsibility of the referring HMO.

- HRSA may pay for services not covered by the HMO if HRSA covers the services.

Note: For further information, refer to the specific program billing instructions.

Exception: HMO clients living outside of the HMO catchment area (within a 25 mile radius of the nearest HMO facility) will be coded with **HM99**. Only **emergent** services provided to these clients are payable by the HMO. The HMO requires proper notification of any emergent services before they make any payment(s). HRSA considers payment for nonemergency services for these clients.

The provider is responsible for obtaining notification approval from the HMO. Usually this must be done within 48-72 hours from the time the service was provided.

Multiple Services

When multiple services are provided, the provider must itemize each service and indicate the applicable third-party reimbursement for each service. HRSA reimburses for covered services

according to the maximum allowable rate listed in HRSA's specific program billing instructions.

Rebilling

If the insurance reimbursement amount is less than the HRSA allowance or the charges are denied by the third-party resource, resubmit the claim to HRSA. **You must indicate *"Insurance"* in the appropriate box on the claim form or electronic record so the claim will be processed properly**.

When submitting a rebilling that is beyond the 365-day billing time from the date of service, reference the ICN that reflects the specific denial (or attach the Remittance and Status Report) that verifies that the claim was originally submitted within the time limit. (**Note**: If rebilling electronically, the ICN should be indicated in the *Remarks/Comments* field.) **HRSA will deny claims with potential insurance coverage if the claims are submitted without attached insurance information.** For specific information on rebilling claims and submitting adjustments, refer to the *Rebillings and Adjustments* (Section K) of this booklet.

Remittance and Status Report

All third-party liability claims appearing on the paper Remittance and Status Report, in the *Claims in Process* section, with the name and address of the insurance company will be denied with the following EOB:

> **090** - Bill this claim to the insurance company as instructed unless documentation is attached to the claim or is on file to warrant payment of the claim.

For further information about the Remittance and Status Report, refer to the *Remittance and Status Report* section, page J.1.

Evidence of Insurance Termination

When any insurance coverage for the client has been terminated, forward to HRSA a copy of the termination notice from the insurance company or call the Coordination of Benefits toll-free line at **800.562-6136**.

The following documents (or photocopies of them) may be used as verification of insurance termination:

- EOB statement from insurance companies;
- Letter from employer;
- Memo from CSOs or insurance companies;
- Divorce decree;
- Court order;
- Military discharge papers *(DD214); and*

- Client-specific letter on insurance company letterhead.

Third-Party Time Limits

Although the billing time limit for HRSA is 365 days, an insurance carrier's time limit on billing allowances may be different. HRSA has no payment responsibility for late filings with private carriers.

Bill the insurance carrier indicated on the Medical ID card. Providers must meet HRSA's 365-day billing time limit, even if the provider has not received the insurance carrier's notification of action. If a claim is denied due to any existing third-party liability, refer to the Remittance and Status Report for insurance information appropriate for the date of service.

Requesting Reimbursement

HRSA's decision to pay or deny a claim when third-party resources are involved depends on the reimbursement amount paid by the third party.

- When the insurance payment is less than HRSA's maximum allowable rate for the services performed, HRSA pays the difference between the third-party payment and HRSA's maximum allowable rate.

- When the third-party payment is as much as or more than HRSA's maximum allowable rate, the claim has been paid in full. HRSA makes no further payment. Do not bill the client for balances. The provider must accept the HRSA rate (when paid by HRSA or a third party) as payment in full.

- HRSA pays sales tax when appropriate for taxable items on the allowed amount minus the insurance payment. When indicating the insurance payment, providers must exclude any sales tax the insurance company paid to the provider.

Questions and Answers

1. Where does DSHS get third-party information?

From any of the following:

- Clients;
- Employers;
- Medical providers; and
- Special data matches.

2. How can the provider of service assist HRSA in updating TPL records?

Forward the insurance carrier's EOB or correspondence to the Coordination of Benefits section. Call the Coordination of Benefits section toll-free at **800.562-6136** with any informational updates that apply. Clients may also call this toll-free number.

☞ **Note***:* Any information received is subject to verification by HRSA.

3. How can a Medical Assistance client also have health insurance coverage?

A client may have insurance coverage through any the following:

- The client's employer (if the client's income allows the client to qualify for assistance);
- An absent (noncustodial) parent;
- Other family members; or
- Benefits resulting from health care reform activities.

☞ **Note:** DSHS pays premiums for those clients who have a health insurance plan available to them which meets the department's criteria for cost effectiveness.

4. How can providers determine if the client has third-party liability?

By doing any of the following:

- Asking the patient at the time the service is given;
- Checking the Medical ID card;
- Contacting Coordination of Benefits at **800.562-6136**;
- Using the Medical Eligibility Verification (MEV) System. To find out more about MEV, see page C.2; or
- Using the WAMedWeb (270/271 transaction) https://wamedweb.acs-inc.com/ .

5. Must third-party resources be used before HRSA pays?

Yes. All resources available to the client must be used prior to payment by HRSA unless federal exceptions apply. (See page I.1.)

6. What can providers do to facilitate processing of third-party claims?

Providers can help by doing all of the following:

- Prepare the claim according to appropriate billing instructions;
- Submit all backup information regarding each claim (RAs, EOBs, accident reports, etc.) if available; or submit appropriate remarks; and
- Make sure the date(s) on the insurance information (e.g., RAs, EOBs, accident reports) correspond to the date(s) on the claim.

7. What can a provider do when the provider hasn't received a payment from the insurance company (the insurance company is not cooperative)?

If the insurance company is not cooperative, call the Coordination of Benefits toll-free number: **800.562-6136** for assistance.

8. What can providers do when the client or subscriber is not cooperative?

The client assigned all medical insurance/medical support to the department when the client became eligible for HRSA services. As a result, the client's cooperation is required to maintain continued eligibility. If the client is **not** cooperative, call the Coordination of Benefits toll-free number: **800.562-6136**.

9. How can a provider avoid recoupment of payments made by an insurance company?

If a provider receives payment from an insurance company for services that HRSA has paid, the provider must **immediately** refund to HRSA either HRSA's payment or the insurance payment, whichever is less.

10. May a provider bill the client when insurance doesn't pay?

- No. The provider bills HRSA for covered medical services.
- The provider may bill the client for noncovered services *if* the client has chosen to receive and has agreed to pay for these services in writing ***before*** receiving the services. (See the *Billing* section.)

11. What does a provider do if the client receives an insurance payment and does not pay the provider?

If the client is the subscriber, the provider may bill the client the same way the provider would bill a private patient. The client/subscriber's name can be turned over to a collection agency if necessary.

12. What does a provider do when the subscriber (*other than* the HRSA client) of the insurance policy receives payment and does not pay the provider?

The provider bills the subscriber. The provider **does not** bill the client. The subscriber's name can be turned over to a collection agency, if necessary.

Remittance and Status Report

Providers use the Remittance and Status Report (RA) to determine the status of claims. The Health and Recovery Services Administration (HRSA) generates RAs weekly. The RA provides a detailed summary of all transactions that HRSA has processed during the previous week. RA Newsletters are kept for several years on HRSA's web site: http://maa.dshs.wa.gov/download/RANews.htm

Providers who conduct electronic business with HRSA can download an Electronic Remittance Advice (EPR or 835 Transaction) from the WAMedWeb (https://wamedweb.acs-inc.com/). **Note:** The 835 Transaction requires the use of software to translate it into a readable format. HRSA does not supply the 835 Translation software. The 835 transactions are displayed on the WAMedWeb for 60 days.

The following is an explanation of the Remittance and Status Report and the Newsletter:

1. **Newsletter**: The *remittance newsletter* comprises the first two pages of the RA. It includes information about claims processing policies. **Read this section each week**. Messages may concern rate changes, revised billing procedures, and many other items that may affect providers immediately.

2. **Paid Claims**: This section shows all claims paid during the previous week.

3. **Denied Claims:** This section shows claims denied during the previous week.

4. **Claims in Process:** This section shows all claims that are still pending. *This section is informational only*. Do not take any action on claims displayed here. Do not rebill. It may take up to eight weeks for paper claim submissions to appear in the *claims-in-process* section of the RA.

5. **Credit Balance Claims:** These claims are considered *in process* and are held in suspense until a credit to HRSA has been met.

6. **Adjustments: Paid Claims**: These are adjustments to previously paid claims where HRSA has recouped the original payment and issued appropriate repayment.

7. **Adjustments: Denied Claims**: These are adjustments to previously denied claims where HRSA has recouped the original payment and denied claims.

8. **Adjustments: In-Process Claims**: These are adjustments to previously paid or denied claims that have not been finalized.

9. **EOB Messages:** Explanation of Benefits (EOB) codes or HIPAA adjustment reason codes are used to explain why your claim was paid or denied.

Refer to HRSA's Provider Relations web site for more information about the RA:
http://maa.dshs.wa.gov/provrel/eob.htm

A Key to the Paper Remittance and Status Report

1. **Provider Name and Address:** Your business name and address as recorded with the HRSA Division of Program Support (DPS) will be listed here.

2. **Provider Number:** The 7-digit billing (pay to) number assigned to you by DPS. Use this number with all correspondence and billings.

3. **RA Number:** This field is used to list the Remittance and Status (RA) Report number and your telephone number.

4. **Date:** This is the date the RA was issued.

5. **Page Number:** The page number of your RA.

6. **Patient ID:** Patient identification is indicated by:

   IN: First and middle initials (a dash (-) may be used if the middle initial is not known).
   DOB: Date of birth.
   TB: Tiebreaker - an alpha character automatically assigned
   NAME: Full last name.

7. **Patient Account Number:** Your *patient account number* will appear here if you entered one on your claim form. This is an alphanumeric field that you may use as your internal reference number. You may want to consider using this number to separate various accounts associated with your office (e.g., to separate different branch office accounts).

8. **Claim Number:** The Division of Program Support (DPS) assigns a 17-digit internal control number (ICN) to each claim received. Use this number when you have any questions concerning your claim. The Julian calendar is used to record the date your claims were received by DPS. The claim number represents the following information:

0	**00**	**334**	**11**	**001**	**000100**
A	B	C	D	E	F

   A Claim Medium:
   - 0 = Exam Entry/ Hard copy claim
   - 1 = Direct entry
   - 2 = Magnetic tape claims
   - 3 = Electronic media claims
   - 4 = State-system (MMIS) generated mass or gross adjustment

   B Year of Claim Submission
   C Julian Date
   D Camera & Reel Number
   E Batch Number
   F Claim Number
   - 0 = initial claim
   - 1 = credited claim
   - 2 = adjustment to initial or previously adjusted claim

9. **Service Date:** Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns.

10. **Day:** The number of days or units billed on your claim.

11. **Procedure/Revenue/NDC:** The CPT and/or HCPCS code, revenue, DRG code, or NDC billed will appear in this column. If you used a modifier, it will also appear in this column.

12. **Total Charges:** The amount you billed.

13. **Total Allowed:** HRSA's maximum allowable rate.

14. **Sales Tax:** Sales tax paid to you, if applicable.

15. **Other Deducted Charges:** Health or other insurance, client participation, Medicare payment amounts, etc., deducted from your payment.

16. **Payable Charges:** Amount payable to you. This amount is either:

    (a) the *total allowed*, *minus* other deducted charges, *plus* sales tax (if applicable);
    (b) the deductible and/or coinsurance amount; or
    (c) the hospital total allowed multiplied by the reimbursement rate.

17. **RR % (Reimbursement Rate):** For hospitals billing non-DRG claims, this is a percentage rate determined by HRSA that is applied to the total allowed amount for the services.

18. **Paid Amount:** Total amount paid after applying all deductions, including the reimbursement rate (RR%), if applicable.

19. **EOB Codes.** A four-digit code which explains how and why the specific service was paid or denied. These codes and their meanings are listed at the end of your Remittance and Status Report.

    The ***total check amount*** and ***year-to-date check amount*** appear at the end of your Remittance and Status Report. The ***total check amount*** reflects the amount of the enclosed warrant. The ***year-to-date-check*** amount reflects the total amount paid to you for the current calendar year.

***Note*:**

Warrants will not be issued if the final claims page on the Remittance and Status Report states, "PAID BY ELECTRONIC FUNDS TRANSFER TO ACCOUNT NO. XXXXXXXXX."

Warrants will not be issued for amounts less than $1.00. If the amount owed to you is less than $1.00, the claim will appear under the heading Credit Balance Claims.

Sample Remittance and Status Report

Electronic Funds Transfer

Electronic funds transfer (EFT) for payment of medical claims and/or premiums is available to Health and Recovery Services Administration (HRSA) providers.

How EFT Works

With EFT, HRSA deposits funds directly to your bank account each week that a payment is due. Funds are available on Tuesdays. If Monday is a state holiday, funds will be available on Wednesday. This process does not affect the delivery of the Remittance and Status Reports that you currently receive with your payments. You will continue to receive these through the mail if you receive a paper Remittance and Status Reports.

How to Set Up EFT

To receive payment through EFT, complete and return to HRSA the authorization agreement **Authorization Agreement for Electronic Funds Transfer (EFT)**, DSHS form 18-633. (See *Important Contacts* section for information on how to download or order DSHS forms.)

- Send it to HRSA at
  HRSA Electronic Funds Transfer
  PO Box 45505
  Olympia, WA 98504-5505

Three test transactions must be processed in order to verify that transmissions to your bank have been successful. During this time, HRSA will mail checks directly to you.

If your account information changes, please contact the Medical Assistance Customer Service Center immediately at 800.562-3022. Failure to do so may result in incorrect deposits or payment delays.

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Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems providers experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may **rebill or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be rebilled or adjusted within 15 months from the date of service (see page H.2).

> ☞ **Note:** The Health and Recovery Services Administration (HRSA) does not accept any claim for rebilling or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

Rebilling

Rebill when:

- **The entire claim is denied**. Check the Explanation of Benefits (EOB) denial code(s), then make the appropriate correction(s) and rebill the claim on a regular billing form, not the adjustment form.

- **An individual line is denied on a multiple-line claim**. The denied service may be submitted as a rebill on a regular billing form, not an adjustment form. **Note:** When billing for surgical claims, refer to HRSA's *Physician-Related Billing Instructions* (see *Important Contacts* section).

> ☞ **Note:** Refer to the *Billing* section for information on how to bill Medicare/ Medicaid claims.

How to Rebill

- Read the EOB code(s), then make any necessary corrections on a copy of the claim **or** produce a new claim with the correct information. Remember to line out or omit all previously paid lines on the claim before sending it back to HRSA. Be sure to adjust the total.

- If the claim was denied for other insurance, attach insurance information or other required documentation to the corrected claim, and send it to HRSA.

- Providers billing electronically may rebill claims via the WinASAP2003 or WAMedWeb applications.

- **If rebilling a paper claim, use the Corrected Claim - Standard Cover Sheet, DSHS form 13-741 when resubmitting your claim**. (See *Important Contacts* section for information on how to download or order DSHS forms.)

Note: When rebilling the claim after the billing time limit has expired, or more than 365 days from the original date(s) of service on the claim, **enter the 17-digit claim number in field 22 (HCFA-1500/CMS-1500) or in the form locator 84 (UB92).** This claim number is proof of timeliness. Providers have 36 months from the date of service to rebill claims, or 15 months for prescription drug claims.

Adjustments

You may submit an adjustment for a claim only when:

- The claim was paid, and an error was made (e.g., wrong procedure code) that may affect payment.

- The claim contained multiple surgical procedure codes, and one of the surgical procedures was denied or paid incorrectly.

- The claim was overpaid. See *How to Adjust Overpayments* on page L.3.

Note: Providers billing electronically may submit adjustments for claims via the WinASAP2003 or WAMedWeb applications.

Which form do I use for adjustments?

Submit **adjustments** on the **Adjustment Request (525-109)**, DSHS form 13-715. (See *Important Contacts* section for information on how to download or order DSHS forms.)

Use only *one* adjustment request form per claim. Submit **multiple line corrections to a single claim on one adjustment request form**. Be sure that proper documentation is attached to your adjustment request (operative reports, insurance EOBs, Remittance and Status Reports, etc.)

MMIS will locate the claim to adjust. The entire original claim will be credited back to HRSA to allow the adjustment to pay correctly. The message *CRE* will appear in the EOB column on the HRSA Remittance and Status Report.

How to Adjust Overpayments

- **Submit an adjustment**: HRSA will recoup your claim and deduct the excess amount from your future remittance check(s) until the overpayment is satisfied;

-Or-

- **Issue a refund check payable to DSHS**: Attach a copy of the Remittance and Status Report showing the paid claim and include a brief explanation for the refund (e.g., insurance payment, duplicate payment).

  Mail this to:
  Finance Division
  PO Box 9501
  Olympia WA 98507-9501

Note: Submit an adjustment or refund by check. Do not adjust and refund for the same claim.

How to Complete the Adjustment Request Form

Submit adjustments on the **Adjustment Request** form DSHS 13-715, available on line at http://www1.dshs.wa.gov/msa/forms/eforms.html . Use only *one* adjustment request form per claim. Submit **multiple line corrections to a single claim on one adjustment request form**. Be sure that proper documentation is attached to your adjustment request (operative reports, insurance EOBs, Remittance and Status Reports, etc.). The numbered blocks on the form are referred to as *fields*. There are only three required fields on the Adjustment Request form: 1, 2, and 3. Complete the fields as explained below.

Field # Description

1. **Claim Number to be Adjusted**: Required. Enter the 17-digit claim number of the claim to be corrected. Submit only one adjustment request per claim.

2. **Provider Number**: Required. Enter your assigned provider number as indicated on the Remittance and Status Report.

3. **Patient PIC Number from RA.** Required. Enter the PIC number from the Remittance and Status Report.

Failure to properly fill out fields 1, 2, and 3 may result in denial of the adjustment request.

4. **Date(s) of Services:** Optional field. Enter the dates of service on the claim.

5. **Date of Request:** Enter the day that you are completing the Adjustment Request.

6. **Patient's Name**: Enter the name of the client.

Field # Description

7. **Items to be Corrected:**

   a. **Line/Date:** Enter the line number(s) or the date(s) of service.
   b. **Information from RA/Original Claim:** Enter the information on the **original** claim.
   c. **Corrected Information:** Enter the corrected information. If there are many corrections to be made to the claim, it may be necessary to submit a **complete** corrected claim with the adjustment request.

8. **Other Remarks**: Use this space to enter any other reasons for the adjustment to be processed (back-up documentation, client Medical ID cards, etc.).

9. **Third Party Insurance Information**: Enter the name of any other insurance company and amounts paid, balance owing.

10. **Provider Name and Address**: Enter the provider mailing address here.